B.O.I. File 93-0057

In the Matter of a Board of Inquiry
appointed pursuant to s. 38(1) of the
Human Rights Code, R.S.O. 1990, c. H.19

BETWEEN

Ontario Human Rights Commission

- and -

Margo Patricia Burns
Complainant

- and -

South Muskoka Memorial Hospital Board,
Patricia Northmore and Frank Lovelock
Respondents

Date of Complaint: April 13, 1992 (Amended)
Board of Inquiry: Professor T. Brettel Dawson
Date of Decision: 13 July 1994

Counsel: Peter Abrahams, for the Ontario Human Rights Commission
Robert Hickman, for the Respondents

Introduction

Margo Burns is a Registered Respiratory Technologist. She was employed by the South Muskoka Memorial Hospital Board (hereafter the Hospital) as Director of the Cardiopulmonary Department on October 11, 1988. This Department was a new service being developed by the Hospital and Ms. Burns was to be the first Director and sole member of the unit. Ms. Patricia Northmore is Director of Patient Services at the Hospital and was Ms. Burns' direct supervisor. Mr. Frank Lovelock is the Chief Executive Officer of the Hospital.

In mid-December 1988, Ms. Burns became ill and was hospitalized with problems related to her pancreas. Throughout 1989 her illness recurred and necessitated extensive periods of sick-leave from her employment. In July 1989, the condition underlying these illnesses was re-confirmed as stemming from a congenital abnormality of her pancreas, known as Pancreas Divisum. This condition can (and in Ms. Burns' case did) lead to intermittent attacks of pancreatitis or chronic biliary colic, the onset of which is relatively rapid. In August 1989, Ms. Burns had the further misfortune of being hospitalized and off work as a result of a motor vehicle accident.

In December, 1989 a point of decision was reached and correspondence was exchanged. The Hospital indicated to Ms. Burns that it was undertaking a review of her "employment situation" and it requested a medical assessment of her condition and prognosis. Ms. Burns in turn requested a medical leave of absence and offered her resignation should the leave of absence not be granted. On January 09, 1990, the hospital advised that the leave of absence was denied and her resignation accepted.

On June 25, 1990, Ms. Burns filed a complaint with the Ontario Human Rights Commission (hereafter, the Commission) alleging that her right to equal treatment with respect to employment and freedom from harassment in the workplace had been infringed contrary to sections 5(1), 5(2), and 9 of the Human Rights Code, R.S.O. 1990 c. H.19 (hereafter, the Code). She further alleges that a leave of absence policy of the Hospital could be considered to have an adverse impact on persons suffering from a handicap. This complaint was amended on April 13, 1992 (Exhibit #48). I was appointed by the Minister of Citizenship to hear and decide this amended complaint, by letter dated February 07, 1994 (Exhibit #1).

When the hearing in person convened on March 01, 1994, counsel for the Respondents indicated that he intended to bring a motion that the complaint should be dismissed on account of delay. On the following day, at the outset of his cross-examination of Ms. Burns, Mr. Hickman indicated that he intended to bring a further motion that the complaint be dismissed for non-disclosure by the Commission. These motions were brought and argued on May 06, 1994 after the conclusion of the evidence. I will consider these motions first, as my decision on them will determine whether I proceed to the merits of the case.

Motions to Permanently Stay the Complaint

A. Delay

Mr. Hickman placed his argument that the complaint should be dismissed for delay on two bases. First, he argued, in relation to the individual Respondents, Ms. Northmore and Mr. Lovelock, that the delay in this case violated their rights to "security of the person" under section 7 of the Canadian Charter of Rights and Freedoms (hereafter, the Charter). Secondly, he argued that the delay, in relation to all Respondents, had breached their rights to natural

justice and procedural fairness, and thus constituted an abuse of the process of the Board of Inquiry. In his submission, the complaint should be stayed on that basis.

Chronology

The chronology associated with the complaint is as follows. Ms. Burn's original formal complaint was filed with the Commission June 25, 1990. The Complainant had been in touch with the Commission as early as September 1989, prior to the end of her employment with the Hospital. The Respondents filed their Response in October 1990. They heard nothing further from the Commission for some 18 months at which point they received a copy of Ms. Burns' amended complaint dated April 13, 1992. The Respondents filed their response to the amended complaint on June 26, 1992. The Commission contacted the Respondents' solicitor on September 03, indicating that they were beginning their investigation of the complaint. Interviews of hospital management and employees were held on October 14, 1992, and the Case Summary was forwarded to the Respondents on February 10, 1993. Their Response was submitted to the Commission on March 24, 1993. Five months passed. Mr. Hickman wrote to the Commission at the end of August requesting an update. Two months later, on November 08, the Commission advised Mr. Hickman that they had been unable to resolve the matter through their normal procedures of investigation and conciliation and that the matter was being referred to the Commissioners for a decision about whether or not to request the appointment of a Board of Inquiry. A Case Addendum, dated November 07, was enclosed. On November 23, 1993, Mr. Hickman submitted a Response to the Case Addendum. On January 31, 1994, the Chief Commissioner wrote to the Respondents advising that the Commission had decided to request the appointment of a Board of Inquiry. The Board of Inquiry was appointed on February 07, 1994. A Case Conference before a separate adjudicator was held on February 16. The hearing before me commenced by way of conference call on February 16 and in person,

on March 01, 1994. The hearing continued on March 2, 14, 15; April 18, 19, 20; and May 6, 1994.

In summary, then, from the date of the original formal complaint until the appointment of a board of inquiry, a period of just over three and one-half years elapsed; calculating from the time of the events alleged in the complaint and the appointment of a Board, the period lengthens to four and one-half years. There were two significant periods of non-communication with the Respondent: an 18 month period between October 1990 and April 1992 (between the response to the original complaint and the filing of the amended complaint), and a seven month period between March 24 and November 08, 1993 (between the response to the Case Summary and the indication that the complaint was being referred to the Commissioners). Some of this second period may have been taken up with conciliation efforts not involving the Respondent. The evidence on this matter was not developed. In this regard, I find apposite comments in Aquil Lasani v. Ministry of Community and Social Services (Ontario Bd. of Inquiry, January 1993, J. House) to the effect that "time which is a consequence of the Commission's attempts to resolve the matter in accordance with the requirement of statute cannot be charged against the Commission". Thereafter, matters moved more expeditiously, indeed as I will discuss in relation to the disclosure point, almost too rapidly. A decision to recommend appointment of a Board of Inquiry followed by the end of December 1993, and from the time of my appointment until the first day of in-person hearing, just 3 weeks elapsed.

(ii) **Section 7 of the Charter, Delay, and the Individual Respondents**

Mr. Hickman's argument, with respect to the individual Respondents, is that the delay in this case violated their rights to "security of the person" under section 7 of the Canadian Charter of

Rights and Freedoms (hereafter, the Charter). Mr. Hickman cited in support, Kodellas v. Saskatchewan (Human Rights Commission) (1989), 60 D.L.R. (4th) 143 (Sask. C.A.) and Motorways Direct Transport Ltd. v. Canada (Canadian Human Rights Commission) (1991), 16 C.H.R.R. D/459 (Fed. C.A.).

In Kodellas, Bayda C.J.S. drew upon comments made by Lamer J. in R. v. Mills, [1986] 1 S.C.R. 863, a case which considered delay in a criminal law context. In Lamer J.'s view, the concept of security of the person encompasses protection against

> "overlong subjection to the vexations and vicissitudes of a pending criminal accusation" These include will stigmatization of the accused, loss of privacy, stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, uncertainty as to the outcome and sanction. These forms of prejudice cannot be disregarded or minimized when assessing the reasonableness of delay" (at 919-920)..

Bayda C.J.S. applied these comments to the human rights context, considering that it was the effect of being accused of egregious personal conduct for a prolonged period of time that was of central importance, rather than the particular forum involved:

> [It] matters not a whit to all of the relevant actors -- the public, the persons who are the source of the hurt, those who are indirectly affected by the hurt... and the alleged discriminator...whether the accusation is made in one procedural forum or another. What matters is the fact of the accusation (Kodellas, at 152).

Although separate reasons for decision were offered by each judge in Kodellas, their approaches were similar. They all concluded that the prospective holding of a hearing after an extensive delay would affect the respondent's self-respect and dignity and, in so stigmatizing him, could infringe section 7 of the Charter. The complaint of sexual harassment was stayed because of the delay. The Motorways case involved a corporate respondent to whom section 7 of the Charter is inapplicable. However, the Court adopted the reasoning in Kodellas as being an embodiment of common law principles and stayed the complaint in that case because of the extensive delay.

An analysis of section 7 of the Charter involves two steps. It must be found first that there has been a deprivation of protected interests in "life, liberty or security of the person". If so, it must then be determined whether the deprivation is contrary to the principles of fundamental justice (R. v. Beare, [1988] 2 S.C.R. 387, at 401). There is no free standing Charter right to be treated in accordance with the principles of fundamental justice.

The Kodellas and Motorways cases have not been followed by Ontario Boards of Inquiry: Gosh v. Domglass (Ont. Bd. of Inquiry, November, 1991, Hubbard); Crane v. McDonnell Douglas Canada Ltd. (Ont. Bd. of Inq., January 1993, Cumming); Simms v. Seeburn Metal Products Ltd. (Ont. Bd. of Inq., April 1993, Cumming); Lampman v. Photoflair Ltd (Ont. Bd. of Inq., September, 1992); Shreve v. City of Windsor (Ont. Bd. of Inq., March 1993, Kerr); Hall v. A-1 Collision (Ont. Bd. of Inquiry, August, 1992, Dawson).

In Shreve, Professor Kerr noted, in relation to section 7 arguments, that proceedings under the Code are civil and remedial and not penal. He found that "the rationale of the decision in Kodellas is simply not applicable under the Ontario Code" (at 15-16). In Gale v. Miracle Food Mart; Ontario Human Rights Commission v. United Food Workers International Union, Locals 175 and 633 (Ont. Bd. of Inq. May, 1992) Professor Backhouse held that

> it appears that section 7 of the Charter has no application to remedial proceedings under the Code. There is a fundamental distinction between criminal and quasi-criminal proceedings, in which a person's life, liberty or security of the person may be in jeopardy and human rights proceedings, which are essentially civil in nature (at p. 10).

In Hall, I expressed reservations about the wisdom of readily analogizing grounds of complaint in human rights legislation with conduct controlled by the criminal law and applying protections developed in the criminal law context to other contexts. I also expressed my concern that one particular ground of discrimination (sexual harassment) appeared to be singled out as being particularly stigmatizing and commented, "it would be unhelpful to single

out any one ground as particularly egregious or stigmatizing. It is not clear that allegations of other forms of discrimination are viewed as being somehow less egregious or more tolerated" (at 21).

It is true that section 7 rights are not limited to the criminal context alone (See Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.), [1990] 1 S.C.R. 1123 (the Prostitution Reference). But in the Prostitution Reference, Lamer J. stated that the circumstances which attract section 7 protection in regulatory or administrative proceedings, are those where:

> what is at stake... is the kind of liberty and security of the person the state typically empowers judges and courts to restrict. In other words the confinement of individuals against their will, or the restriction of control over their minds and bodies, are precisely the kinds of activities that fall within the domain of the judiciary as guardian of the justice system (Prostitution Reference, per Lamer J., at 1175-76).

In Hall, after noting that these kinds of control were not part of human rights proceedings, I concluded:

> the nature of the allegation and the stigma that may be associated with it and be compounded by extensive delay in a remedial human rights proceeding, is not sufficient to raise an interest within section 7 of the Charter. As neither the consequences or nature of the proceedings attract such an interest either, I find that the Respondent has not passed the threshold of bringing himself within section 7 of the Charter (at 37-38).

In Simms, Professor Cumming concluded that Kodellas and Motorways "are not to be followed by Ontario Boards of Inquiry unless and until an Ontario court rules otherwise" (supra at 7). I agree, and as a consequence, I do not accept the Mr. Hickman's argument that the complaint against the individual respondents be stayed on the basis of section 7 of the Charter. It follows that his motion in this regard is refused.

(iii) Delay and Abuse of Process

Mr. Hickman next argued that the delay, in relation to all Respondents, had breached their rights to natural justice and procedural fairness, and thus constituted an abuse of the process of the Board of Inquiry. Section 23(1) of the Statutory Powers Procedure Act, R.S.O. 1990, c. S.22 (hereafter S.P.P.A.) empowers a Board of Inquiry to "make such orders or give such directions as it considers proper". In Quereshi v. Central High School of Commerce (1988), 9 C.H.R.R. D/4527 (Ontario Bd. of Inquiry, Ratushney) at para 35,253 it was stated that "this subsection appears to provide jurisdiction to dismiss a complaint for reason of delay. However the delay would have to approach the standard of an abuse of the processes of the tribunal." This assessment has been generally accepted by Boards of Inquiry. What then is the standard of an abuse of process and is it applicable in the current proceedings?

In Simms (supra), Professor Cumming stated:

> Mere inconvenience by the delay or the factor simply of fading memories due to the passage of time are not enough, in themselves to establish prejudice, but can be taken into account when assessing the credibility of witnesses or in fashioning an appropriate remedy... Boards of Inquiry require a demonstration of significant prejudice caused by the delay, such as key witnesses being no longer available or other insurmountable problems of proof. (See also Munsch v. York Condominium Corporation Ont. Bd. of Inq., July 1992, at 2)

In Guthro v. Westinghouse Canada Inc. (No. 2) (1991), 15 C.H.R.R. D/388 at D/391:

"Chairperson Gorsky stated:

> The prejudice to a party occasioned by delay must indicate more than inconvenience; it must be sufficiently oppressive to prevent a response or defence from being made. An unreasonable delay creates an insurmountable problem: a key witness has died, documentary evidence has been destroyed, or some other circumstance has limited the opportunity to defend against the allegations made in the complaint.

The decisions in Meissner v. 506756 Ontario Ltd. (1990), 11 C.H.R.R. D/94, and Hyman v. Southam Murray Printing (No. 1) (1982), 3 C.H.R.R. D/617 are of continuing assistance in setting an appropriate standard of prejudice in remedial human rights proceedings in relation to claims of unreasonable delay. In Meissner, the Board of Inquiry pointed out

> It is clear from the preamble and scope of the Code that the public interest is central to the legislation. The public interest includes and transcends the interests of complainants and respondents. At the core of the public interest is the vindication of those rights identified by the Code as human rights (at D/95).

In Hyman, the Board of Inquiry said:

> [W]hile unreasonable delay may be a factor to be taken into account in refusing or fashioning a remedy or in weighing the persuasive ...force or credibility of testimony or other evidence, delay in initiating or processing a complaint should not be considered as a basis for dismissing the complaint at the outset of the proceedings before a board of inquiry unless it has given rise to a situation in which the board of inquiry is of the view that the facts relating to the incident in question cannot be established with sufficient certainty as to constitute the basis for a determination that a contravention of the Code has occurred. Having been assigned... [a] statutorily defined task of undertaking an inquiry to ascertain facts, the board of inquiry should proceed to attempt to do so, notwithstanding the passage of considerable time, unless the passage of time has made fulfillment of its task impossible. In the absence of such, admittedly unlikely circumstances, the proper course, in my opinion, is for the board of inquiry to proceed (at D/621; see also Gosh v. Domglass, supra; Gale, supra at 13).

In Crane, supra, Professor Cummings concluded that the granting of a respondent's motion for a permanent stay because of delay would have a harsh impact on the complainant's rights and hence that a substantial burden was placed on respondents to demonstrate that the delay was so severe that the only fair course of action was to dismiss the complaint at the outset. In Hall, supra, I concluded that evidence supporting actual prejudice is required. In Naraine v. Ford Motor Co. (Canada) (Ont. Bd. of Inq., April 1994, Backhouse), the Board accepted that the appropriate test "appears to be that whether the passage of time has rendered it **impossible** for this Board of Inquiry to determine whether a breach of the Code occurred" (at 14).

The only Ontario Board of Inquiry decision to date, granting a stay or dismissal of a complaint circumstances including unreasonable delay is Shreve, supra. However, the Board in that case made it clear that it was the particular combination and inter-relation of bias on the part of the Commission's investigating officer, insufficient disclosure, and significant delay which lead to his conclusion that the ability of the respondents to prepare their case in a timely fashion had

been so seriously prejudiced as to warrant a stay of proceedings. In Naraine, Professor Backhouse commented that the ruling in Shreve was made in the "peculiar facts of that case", and she went on to express concern lest its impact be seen to "divert resources away from adjudicating the fundamental matters which underlie human rights disputes, and require boards of inquiry to sit in supervision over the bureaucratic processes of human rights investigations instead" (supra, at 20).

In the present case, I have had the advantage of hearing the evidence, as the motion to dismiss for delay was argued after its completion. It is true that a significant period of time has elapsed since the events alleged in the complaint and the date of the original complaint, although far less egregious than in many other cases where motions to dismiss for delay have been refused. It is true that a slow pace characterized the processing of the file and that a speedier process would be in the interests of everyone. It is also true that the memories of some witnesses appeared to have faded. Nevertheless, all relevant witnesses and many important documents and records were available. There was no evidence of actual prejudice occasioned by the delay. It was clear to me that the respondent was not prevented from preparing a defence. Nor do I consider that the passage of time has rendered it impossible for me to be able to determine whether a breach of the Code occurred. Perhaps ironically, by dint of excellent preparation by the Respondents' counsel, together with the Commission's evidence, I consider I that I have a generally full and thorough evidentiary record on which to base my determination.

I believe the circumstances associated with delay in this matter fall well below the standard approaching abuse of process and accordingly, I refuse the Respondent's general motion that the proceedings be stayed or dismissed because of delay. Given that there was some delay in this case and that it may have had an effect on the evidence presented, this will of course, be a factor which I will take "into account in refusing or fashioning a remedy or in weighing the

persuasive ...force or credibility of testimony or other evidence" (Hyman, supra) or more simply "when it comes to weighing the evidence and fashioning the remedy in this complaint" (Naraine, supra at 16).

B. Disclosure

The Respondent, by affidavit and in argument, raised several concerns about disclosure by the Commission. Several documents were not made available until the Case Conference held on February 16, 1994: a medical report from Dr. Keith (Exhibit #3), information regarding the Complainant's financial loss, and witness statements other than those taken from management staff. It appears that a wider range of witness statements was made available after that time. After the hearing had commenced, the Respondents received documentation regarding the Complainant's income loss and, after dialogue on the matter, copies of letters and memos received by the Complainant from the Hospital during her employment and on which she had made contemporaneous notes and which she had made available to the Commission from the outset.

When the matter of disclosure of these documents was raised on March 03, 1994, Mr. Abrahams indicated that the Commission had assumed that the Respondent, as originator, had copies of them, that he had introduced all relevant documents into evidence and that, with respect to the notations themselves, he had no objection to providing all such items to the Respondent forthwith. He did so by letter of March 04, 1994. One of these forwarded documents included what I assume was an initial, informal complaint by the Complainant filed in September 1989, prior to the end of her employment, and which the Respondents had not seen before.

The Respondents also objected that issues were raised by the Complainant during her evidence of which they had no prior notification and which were not alleged in the complaint. These issues included what the complainant was told about the cardiac testing at her initial interview, whether the workload was excessive, whether she was eligible for or received a pay raise, and whether a replacement respiratory technologist might have been available to the Hospital.

The matter of the appropriate amount and timing of disclosure by the Commission to respondents in human rights matters has been the subject of increasing attention. Several statutory enactments are relevant. Section 8 of the S.P.P.A. provides that:

> Where the good character, propriety of conduct or competence of a party is in issue in a proceeding, the party is entitled to be furnished prior to the hearing, with reasonable information of any allegations with respect thereto.

Pursuant to section 12(1)(b) of the S.P.P.A, a tribunal may require a person, by summons, to "produce in evidence at a hearing documents and things specified by the tribunal", and section 39(4) of the Code provides that where this power is exercised, a board of inquiry "may upon the production of the documents or things before it, adjourn the proceedings to permit the parties to examine the documents or things."

It was generally held that disclosure in human rights proceedings was not true civil or criminal law discovery, but could be limited to the provision of "reasonable information" depending on the circumstances of the case and sufficient to ensure that the Respondent was aware of the case to be met. In Dudnik v. York Condominium Corp. (1990), 12 C.H.R.R. D/325, the Board stated that the Commission

> being the entity charged with furthering the public policy underlying the Code ...is not an adversarial party to a respondent in the fashion of adversarial parties in a civil action... From a practical standpoint, generally counsel to the Commission will provide counsel for the respondent with copies of the documents intended to be relied upon by the Commission and a disclosure statement, in advance of the hearing.

The right to disclosure under the S.P.P.A. was thought to be satisfied by information as to the substance of the allegations of improper conduct (Salamon v. Searchers Paralegal Services (1987), 8 C.H.R.R. D/4162, at D/4164-6) which was taken to mean, as commented in Shreve, supra at 19 "while a respondent may be entitled to further particulars so as to enable it to identify relevant events, ...this does not mean disclosure of witness statements or even the names of witnesses upon whose testimony the Commission intends to rely" (also citing Adair v. K.B. Home Installation Ltd (1991), 15 C.H.R.R. D/331 at D/332). In Simms, supra at 11, the Board noted that the Commission had agreed to provide further particulars of the evidence to be introduced and stated, "Should Respondents be taken by surprise by any evidence sought to be introduced at the hearing, the appropriate course to consider is to grant an adjournment."

The most recent authority on the subject is the decision of the Ontario Divisional Court in Ontario Human Rights Commission v. House, Northwestern General Hospital (unreported, Ont. Div. Ct, November 8, 1993) (the Northwestern Hospital case). This was an appeal from an order, granted by Chairperson House sitting as a Board of Inquiry, that the Commission provide the respondents in that case

> all statements made by the Complainants to the Commission and its investigators at the investigation stage, whether reduced to writing or copied by mechanical means. I further order the Commission to provide the Respondents with the statement and identity of any witness interviewed by the Commission or its agents, who the Commission does not propose to call and whose statement might reasonably aid the Respondents in answering the Commission's case.

It was also implicit in his decision that a wide range of material related to the investigation of a complaint should be disclosed including all witness statements (in a given case, those witness statements might need "to be edited prior to disclosure to ensure that identities may not be prematurely and inappropriately raised", at 15).

In his decision, Chairperson House analogized the role of Commission counsel to the duties of Crown counsel in a criminal proceeding and he relied upon R. v. Stinchcombe, [1991] 3

S.C.R. 326 as the basis for his conclusion that "any relevant materials not otherwise privileged ought to be disclosed to counsel for the Respondents" (at 13). He separated the stages of a human rights procedure into the investigation stage, the conciliation stage, and the "prosecution" stage after the appointment of a Board of Inquiry. He held that communications and materials produced in the conciliation and prosecution stage are privileged. Finally, he concluded that the timing of disclosure "should be entirely in the hands of the Commission counsel, whose decisions, absent a showing of oblique motive, must be respected as those of an officer in the Court" (at 14).

The Divisional Court placed its decision on a slightly different footing than the Board of Inquiry. The analogy with criminal proceedings or the role of Crown counsel was less important than the general principles enunciated in Stinchcombe. In Stinchcombe, the Supreme Court judges had noted that in civil proceedings "full discovery of documents and oral examination of parties and even witnesses are familiar features of the practice", and they emphasized that "justice was better served when the element of surprise was eliminated from the trial and the parties were prepared to address issues on the basis of complete information of the case to be met." They further recognized that the "fruits of the investigation are not the property of the Crown for use in securing a conviction but the property of the public to be used to ensure that justice be done" (at 331). The Divisional Court agreed that the investigation stage must be distinguished from the "litigation" stage wherein privilege could be asserted. The Court was not sympathetic to Commission arguments that communications and materials were created generally on the basis of an "expectation of confidentiality" but did emphasize that the requirements of natural justice depend on the particular circumstances of each case. It offered no comment on the timing of disclosure.

It is clear that the Northwestern Hospital case has expanded and formalized the disclosure obligations of the Commission as a public body in relation to communications and documents

gathered during the investigation stage of complaints. A much wider range of relevant material should now be disclosed as a matter of practice, including witness statements and all statements made to the Commission by complainants and generally, "the fruits" of the Commission's investigation.

In this case, Mr. Hickman argued that it was unfair that Commission counsel had access to all information while he had only the documents he could secure. He argued that the disclosure in this case was incomplete and untimely and had prejudiced his ability to put his case together, and further, that he had been taken by surprise by issues brought out in the Commission's case. These factors, in his submission, amounted to an abuse of the processes of the Board. For the Commission, Mr. Abrahams argued that the Respondent is not entitled to the whole file but only what is relevant, that the obligation to provide information arises only after the Board of Inquiry is appointed, and that the timing of disclosure is in the hands of Commission counsel. He submitted that when the point had arisen, he had opened his file to the Respondents' counsel. He further noted that Mr. Hickman had not requested an adjournment and that after the second day of hearing, during which the issues about notations made by the complainant and new items in her evidence had arisen, there had been a 12 day break.

I have considerable sympathy for the Respondents' position. It is true (and generally speaking, appropriate) that the Commission assists complainants and it is true that the Commission moves from carriage of an impartial investigatory process to carriage of, and advocacy for, a case before a board of inquiry. This is in the nature of the legislative schema and underlines the element of public duty involved in the activities of the Commission. Yet, information about financial and, specifically, income losses may well have been relevant to the Respondents at an earlier stage. It was apparent to me in the hearing that new items and documents were indeed being raised. Some of the matters disclosed for the first time in

evidence will require my close scrutiny in weighing the evidence, assessing credibility and fashioning any remedy. However, I agree with Commission counsel that the timing of disclosure is within Commission counsel's discretion and that the bulk of material was disclosed prior to the commencement of the hearing. I think that the breathtaking speed (in comparison to common experience in these matters) with which the complaint proceeded to an actual hearing, limited the time for disclosure, whilst furthering an additional important aim of moving expeditiously to a hearing.

The truly contentious issues appear to be the notated documents, the "new" allegations, and the figures for income loss, all of which became known to the Respondents only after the hearing commenced. In my view, Mr. Abrahams acted properly in immediately making available the notated documents and obviating the need for an order for disclosure. In this case, the extent of the notes suggests that they were in the nature of statements made by the Complainant to the Commission. However, I am persuaded that the break in the hearing dates provided sufficient time for the Respondents to peruse abd respond to the material. The same follows for the figures for alleged income loss.

In relation to the new issues raised by the Complainant in her evidence, it transpired in cross-examination that the Complainant did not assert that the alleged discrepancy between the job on arrival and as outlined in the interview, and the allegedly excessive workload, were ways in which she was harassed or discriminated against (Vol. 2, at 104). These allegations, which were explored by the Respondents, became a matter of credibility and overall context. The availability or not of a replacement respiratory technologist relates to accommodation, and as disputed matter of fact, will be weighed carefully in light of the lateness of the disclosure.

I am more troubled by the new specific allegation of a particular instance of harassment or discrimination, perhaps even adverse impact discrimination (Vol. 8 at 49), which was raised

by the new allegation of a withheld pay increment. I am unsure whether documentary disclosure would have identified this issue -- as I am unclear whether it appears in the documents or whether it was a matter investigated by the Commission. It was not a matter to which the Respondents had an opportunity to respond during the earlier processes. This allegation was not part of the amended complaint, and I accept that, until the second day of hearing, the Respondents were not aware of this allegation. It became apparent in the hearing, that the person alleged to have made this decision was the Director of Human Resources, who was mentioned only once in the complaint as having been in attendance at one meeting. She was not a named party (Vol. 7 at 39), nor was there any discussion that she should be added as a party.

The evidence suggests that the Hospital had a policy of annual increments (Exhibit #16) and that Ms. Burns' increment was deferred. Only vague mention could be made concerning the percentage of the disputed increment and no dollar figure was introduced in evidence. The interpretation and application of the policy generally was not explored. It seems clear that the timing of this allegation had the potential to prejudice the Respondents in preparing their case in a way that would be difficult to cure and it was a new substantive allegation without adequate notice. The alleged incident is relatively small in the overall context of the many stated allegations; the almost overwhelming inference is that this matter was added by the Complainant as an afterthought. I do not think, of itself, that it constitutes an abuse of the Board's process. However, I do not consider it appropriate for me to accept the allegation as part of the substance of the case. At most, it may be a factor to be considered in the fashioning of any remedy.

Accordingly, both motions with respect to delay and disclosure are refused. With these preliminary matters dealt with, I now turn to the substance of the complaint.

The Evidence

As indicated in the introduction, Margo Burns is a Registered Respiratory Technologist (R.T.). In addition to her basic R.T. qualification, she holds an Advanced Certification for R.T., a B.A. and M.A. in Health Studies (Applied), and hospital management certification to Level II.

In July 1988, she was interviewed for a position at the South Muskoka Memorial Hospital Board to be the director of a new department in the Hospital which would provide respiratory therapy services and incorporate an established service for cardiac testing (holter monitors, stress tests, E.C.G.s). Although Ms. Burns' testified that there was no indication during the interview that the cardiac tests would be her responsibility upon taking up the position, I am satisfied that this was discussed at the interview and was further negotiated in October 1988 when she began her employment with the Hospital. It was decided to call the new department "Cardiopulmonary". Ms. Burns was to be the sole member of the Department, although it was hoped to eventually expand the staff complement.

The Need for a Cardiopulmonary Department

For several years before Ms. Burns was hired to establish the Department, the Hospital had wanted to develop its respiratory therapy services. In a proposal submitted to the Ministry of Health and the District Health Council in 1987, reference is made to an "urgently needed requirement for a respiratory therapist to co-ordinate and supplement the existing services in our hospital and update diagnostic and therapeutic equipment to meet present day needs." This document goes on to describe then existing arrangements for respiratory service delivery as resulting in "a fragmented program with no organization and coordination. There is no routine for management of chronic illnesses and education of the nursing staff. All activities are

ected at the acute phase of an illness" (Exhibit #51). Prior to Ms. Burns' arrival, the holter monitoring and stress tests for inpatients and outpatients were managed by nurses in the intensive or constant care unit (C.C.U.). The nurses on the wards did whatever oxygen therapy was needed. The internal medicine specialist, Dr. Caughey, did pulmonary function tests in his own office. Decisions about purchase of equipment were made by the nursing staff. Electrocardiograms (E.C.G.s) were done by the Laboratory Department. Ms. Jane Merkley, who was then Head Nurse in the C.C.U., admitted that the workload in the C.C.U. was increasing, that it was becoming difficult to handle the outpatient testing and that the newer staff in the unit were less comfortable with providing respiratory-related care (Vol. 4 at 70, 73). The 1987 proposal indicated an increasing demand for stress tests, holter tests and arterial blood testing. At that time (and now), 25 per cent of admissions to the Hospital related to respiratory problems and it appears that, with an aging population, the acuity levels of those patients was increasing.

In view of this situation, and although the 1987 funding proposal was not successful, the Hospital decided to proceed with establishing a department to provide existing services and to consolidate and expand available services. Until external funding was obtained, the Department was to be funded out of the general operating budget of the hospital. Additional revenue from OHIP was anticipated for the outpatient cardiac and respiratory testing. This was the context to which Ms. Burns arrived on October 10, 1988. She had previous experience with establishing R.T. departments and she was knew this was to be her task at South Muskoka.

The Components of the Position Held by Ms. Burns

The elements of the position were discussed extensively in evidence and there were several disputes between the parties concerning the actual balance between respiratory and cardiac

testing work, inpatient and outpatient work, the time allocations to particular tests and administration. I tend to think that the assertion by Ms. Burns, that her workload was 75 per cent cardiac and 25 per cent respiratory was not entirely accurate. For now, it is sufficient to outline the elements of the position from the agreed job description and evidence.

It is possible to identify seven main components to the position. The first two components related to clinical work: outpatient testing and inpatient respiratory assessment and treatment (with occasional cardiac testing). It was agreed that the skills involved with much of the outpatient testing were not highly specialized. There was considerable dispute as to the skill specialization required for the inpatient work. I find that the nurses at the Hospital could "cope" with or maintain many situations, but that Ms. Burns as an R.T. had particular skills (eg. in relation to ventilated patients, arterial punctures, and intubations) and a specialized capacity for respiratory involvement in patient care which was prerequisite to the Hospital being able to provide broadly-based inpatient respiratory services.

The third component to the position was general administration. This involved the booking of appointments, paperwork and filing, billing OHIP for outpatient tests, and maintaining statistics. Much of this administrative work was not specific to an R.T. but was closely related to the work of the Department. A fourth component was equipment related: maintenance and calibration of equipment, and stocking of supplies. A fifth component was educative and involved teaching nursing staff (and patients) about particular procedures and pieces of equipment. The sixth component was related to the establishment of the unit and involved the development of policies and procedures, assessment of equipment and recommendations for enhancements, assisting with proposals by which external funding could be secured for the unit, and ensuring that medical staff were aware of the services available and how to access them.

It is also important to note that, in addition to actually providing the services or being a consultant with respect to them, Ms. Burns' was to be the Director of a distinct unit in the hospital, a senior professional position. This seventh, and in my view crucially important component, involved development and supervision of services, and planning in consultation with physicians, nursing staff and her direct supervisor, Ms. Northmore, the Director of Patient Services. Participation in the hospital-wide Quality assurance programme, evaluation of the effectiveness of the program and its services, and participation in various meetings was also part of this "Department Head" component.

Illnesses and Absences from Work as a Result of Handicap

Ms Burns began her employment with the hospital on October 10, 1988. During the course of her employment with the Hospital, which ended on January 09, 1990, Ms. Burns was absent from work due to illness or accident on at least 11 separate occasions and for a total of about 126 days (there were an additional 10 days which may have involved sickness but the evidence was insufficient to be certain with regard to them). The available work days during this whole period were 315. The rate of absence then, was about 40 per cent overall (48 per cent after the end of the three month probationary period), although it reached as high as 63 per cent for some three month periods and 75-100 per cent for some months. With a few exceptions, her absences from work resulted from illnesses related to her pancreatic condition or the motor vehicle accident. Ms. Burns provided basic information on the illnesses and investigations to Ms. Northmore.

In mid-December, she became ill with pancreatitis and was hospitalized at South Muskoka for nine days. Ms. Burns testified that pancreatitis is a condition causing severe back and

epigrastric pain and usually requiring hospital admission for intravenous fluid and pain medication and not eating until the pain subsides (Vol. 1 at 27). The illness has an relatively rapid onset. Ms. Burns was off work for three days in mid-January 1989 and, beginning January 30, she was away from work for three and one-half weeks undergoing tests in London, Ontario. At this time, her physicians were entertaining a possible diagnosis of loin pain hematuria syndrome. An extended period of absence related to illness began on March 30, 1989. Ms. Burns was off work for over seven weeks. Initially she was hospitalized at South Muskoka, but she was subsequently transferred to Wellesley Hospital in Toronto for tests. One of these tests was an ERCP which examines the pancreas. It can also bring on an attack of pancreatitis which occurred and necessitated an additional week of hospitalization. Her physician did not identify pancreas divisum at that ERCP.

At this point it is helpful to review Ms. Burns' medical history prior to her employment with the Hospital, as apparent from documentary and oral evidence. Between 1981 and 1983 she experienced two years of recurring abdominal pain. She had an appendectomy and cholecystectomy in 1981. Her condition appeared to have subsided until November 1986 when she experienced an attack of pancreatitis and, I assume, continuing discomfort which lead to testing, including an ERCP in June 1987 in Winnipeg. At that time, an initial diagnosis of pancreas divisum was made. The condition appears to have again settled. Her pre-employment medical completed in September 1988 indicates that Ms. Burns "had abdominal pain Nov 86 -- Oct 1987. Largely resolved. Currently well" (Exhibit #33). Ms. Burns' testified that she "had been told that it was an unusual thing that had happened and most likely wouldn't happen again since I hadn't had any problems for the two years" (Vol. 1 at 16). That said, it is clear that Ms Burns had a congenital condition and had had intermittent problems with abdominal pain for some seven years. These problems continued after her employment with the Hospital and lead ultimately to two surgeries in 1990 and 1992. Repeat pain was reported in June 1993 (Exhibit #3).

It is also pertinent to note a pattern which emerged at this point of her testimony and continued throughout and which I discuss further below. Part of this pattern was under-estimating the periods of illness or absences. Her pre-employment medical completed by her personal physician stated that Ms Burns had lost 14 days through illness in the previous two years. Ms. Burns' testified that she had lost only seven days (Vol. 1 at 15). While her attendance record at the Hospital indicates the length of absences noted above, Ms. Burns consistently underestimated her absences by about 50 per cent.

Ms. Burns was able to return to her employment by May 19, 1989, but was again absent because of illness on June 22 and 23 and from July 3 to July 7. Another long period of absence began on July 13, lasting three and one-half weeks to August 4. During this period, Ms. Burns was in hospital in Toronto undergoing tests. A second ERCP was performed by a Dr. Haber (followed later by a related attack of pancreatitis). At this time the June 1987 diagnosis of pancreas divisum was confirmed. Mention is made by Dr. Keith, in his report submitted by the Commission (Exhibit #3), to ongoing efforts during this period, to manage Ms Burns' "chronic pain syndrome". Dr. Keith, who became one of Ms. Burns' physicians after the end of her employment with the Hospital, confirmed that "the problems which Margo Burns presented with in 1988 to 1989 were relevant to this problem of chronic abdominal pain associated with pancreatitus divisum." Dr. Keith also commented that "The problem with this condition is that the attacks are unpredictable and are likely to recur, in spite of strict dietary monitoring."

In August 1989, Ms. Burns was hospitalized and off work for three weeks as a result of a motor vehicle accident. She was hospitalized with further complications for two weeks between October 30 and November 10 and suffered a further pancreas-related illness between December 4 and 15, 1989.

Responses to the Situation

These absences had a major impact on the ability of the Hospital to maintain continuity and quality of patient care. They had a major impact on the establishment and integration of the new Cardiopulmonary department into the Hospital. Inpatient respiratory care could not be established or maintained at the same levels. Inservice education sessions were cancelled. Co-ordination and planning became extremely difficult.

Ms. Burns stated that she was "not sure who did what when [she] was away". This statement was obviously correct. For example, she suggested that Joan Box did much of the stress test work, but it appears that Ms. Box was on an extended sick leave herself from April to September 1989. Short of trying to arrange occasional coverage by the C.C.U. or Lab informally (and contrary to Ms. Northmore's instructions), Ms. Burns indicated that she did not make any effort to find a replacement for her during her absences. She did not consider it her place (Vol. 3 at 150). Nor did she inquire into the problems her absences were causing (Vol. 2 at 147). Ms. Northmore testified that at no point did Ms. Burns admit that her absences were causing problems nor did she work with Ms. Northmore to find a solution (Vol. 5 at 103). This testimony is consistent with Ms. Burns own comments in this regard.

In April, Ms. Northmore arranged for a registered nurse, Katherine Galarneau to be trained to perform the outpatient cardiac testing and PFTs. Ms. Galarneau had flexibility in her schedule and continued thereafter to work shifts in this area during Ms. Burns' absences. At various times Ms. Box, or Ms. Northmore herself, performed some of the tests. Ms. Burns, for her part, objected strenuously to the process by which Ms. Galarneau was hired and criticized her training (by Dr. Caughey) and her work. She also objected to what she thought was Ms.

larneau's rate of pay, on which point she was clearly mistaken. Ms. Burns alleged that Ms. Galarneau was receiving $2.00 more per hour than Ms. Burns' own rate of pay (Vol. 1 at 46; Vol. 2 at 158), and that this was inconsistent with the Hospital's stance of budget stringency. However, the evidence shows that Ms. Burns was acting on an unfounded assumption: Ms. Galarneau was paid either a lower technician's rate for some tests, or a lower R.N. rate for other work (Vol. 3 at 185; Exhibit #43).

When Ms. Burns was able to return to work toward the end of May, it was agreed between her and Ms. Northmore that she would take two education days on May 23 and 24 to attend the meetings of her professional association before returning to a modified work plan. This modified work plan was in effect from May 25 to June 09 and involved working partial days and taking the remainder as sick time.

e situation was obviously giving concern to management. At a meeting with Ms. Burns on June 30, Ms. Northmore outlined the percentages of time that she had been absent and stated that better management of the situation was needed. A notation to a memo (Exhibit #37) given at that meeting indicates that Ms. Northmore suggested part-time status or termination as possible options if the noted peer group averages continued to be exceeded. Ms. Burns became very upset. The possibility of part-time work was again raised on July 11, by Ms. Northmore and on August 10 by Mr. Lovelock who discussed with Ms. Burns that "we couldn't continue with the situation as it was" (Vol. 7 at 4). The evidence of the Respondents was that whenever the issue of part-time was discussed, Ms. Burns would become very upset and that she refused to discuss the matter. Ms. Burns herself continuously referred to "being forced to go part-time". I accept Ms. Northmore's testimony that Ms. Burns at no time indicated a willingness to move to part-time status and that she would not discuss the matter (Vol. 5 at 56). Indeed, Ms Burns testified that part of the impetus for her contacting the Commission was that she had

been told that she would be forced to go part-time (Vol. 3 at 154). She testified that she would have been willing to accept part-time work (Vol. 1 at 124) and she indicated as much. I find this evidence misleading and not credible beyond accepting that Ms. Burns accepted that she might be forced to work part time.

On September 22, in a meeting with Ms. Northmore and the Director of Finance, Mr. Frederick, Ms. Burns was given a letter (Exhibit #6) which formalized the position of the Hospital. The letter indicated that a medical report had been received from her physician, Dr. Heath, which indicated that an experimental procedure in relation to the condition was possible. This was a verbal report. The letter stated that, in the hospital's view, Ms. Burns was the only person qualified to perform respiratory therapy and that budget restraints prevented the Hospital from continuing to replace her. The letter went on to indicate that she would be expected to conform to the hospital average of 10 days sick time as of her anniversary date, and that any time loss associated with surgical procedures related to her condition would not be counted in that total. The letter went on to suggest that if Ms. Burns exceeded the 10 day average, she would revert to part-time status.

During this period, concerns arose about overtime accumulation, the substitution of overtime for sick time, and the time left in Ms. Burns' employee sick plan. I discuss these matters in detail below. Conversations took place with the Ontario Hospital Association (the OHA) on October 09 and 10, 1989.

A letter of discipline concerning performance problems, other than those arising directly from her illnesses was issued on October 13. This letter, written by Ms. Northmore, stated that it was prepared:

> in response to the unacceptable situation which exists in our working relationship. In the past year you have selectively ignored my requests and

> decisions and failed to communicate with me about events in your department unless pressured to do so. You have attempted to involve other staff and physicians in support of your position against my actions and when I have insisted on certain requirements you have become hostile and resorted to threats against me and the hospital administration. On several occasions you have made statements which were inaccurate or deliberately misleading and untruthful. This adversarial behaviour has resulted in a complete breakdown of communication between us as well as consuming an inordinate amount of time and energy. This is unacceptable behaviour and can not be tolerated. Unless a spirit of co-operation toward me and administration is maintained, your employment with us could be terminated.

Ms. Burns testified that until receiving this letter she had "never heard of these problems" (Vol. 1 at 121). She also stated that "at first she wasn't allowed to speak", which I find to be either untrue or an unjustified perception.

In fact, Ms. Burns did not herself volunteer information in her evidence about concerns expressed in meetings by her superiors about job performance issues. Evidence which I accept as accurate, discloses that various matters had been raised almost from the beginning. In November 1988, Ms. Northmore discussed with Ms. Burns concerns that some members of the nursing staff were becoming upset because they felt that she was criticizing the way they did things. Ms. Northmore suggested that she be more diplomatic (Vol. 5 at 14). While not recalling this conversation, Ms. Burns did offer the view that "perhaps [she] was just making an observation on the way things were done. It didn't mean it was criticizing anyone" (Vol. 2 at 123). Ms. Northmore also raised a problem of non-work related conversation on the wards which was to be a recurring matter of concern (July 11, 1989: Vol. 5 at 45-46; September 14, 1989).

In early March, Ms. Northmore asked Ms. Burns to notify her personally of any absences and asked her to not to ask the C.C.U. or the Lab to cover her scheduled tests. This request was put into writing on June 19, 1989 (Exhibit #5). The evidence suggests that Ms. Burns had not contacted Ms. Northmore directly on several previous occasions and chose not to contact Ms.

Northmore after this request was formalized (see e.g. Vol. 3 at 49; Vol 5 at 43). At least as late as September, she made some direct coverage arrangements (Vol. 5 at 58). Ms. Northmore had to request in writing to be given monthly Department statistics. On September 14, Ms. Burns' was asked to give two days notice of return to work (Exhibit #5). She had not given notice of return to work in July, nor did she in November (Vol. 3 at 120).

Meetings were also held at which productivity and programme performance were discussed. (e.g. June 30, 1989). A hostile meeting took place on September 22, 1989 during which Ms. Burns indicated that she had consulted with the Commission in Ottawa and suggested that the Hospital's proposed actions were contrary to the Code (see also Exhibit #15). Another hostile meeting took place in Ms. Burns' office on October 10, 1989, following Ms. Burns' contact with the OHA concerning a perceived problem with reinstating her sick bank. Although Ms. Burns had telephoned the O.H.A. on October 09 and been called back on October 10, she denied making a call (technically correct but extraordinarily hair-splitting) and, in Ms. Northmore's evidence, was "belligerent and rude and eventually turned her back on me and continued to work at her desk" (Vol. 5 at 60).

Throughout her testimony, Ms. Burns attempted to minimize the impact that her absences had on the functioning of her Department and the provision of respiratory services by the Hospital. On her own admission, she did not inquire into the difficulties her absences were causing to the Hospital and did not apprise or involve herself concerning arrangements (save in relation to Ms. Galarneau) made by the hospital during her absences (Vol. 2 at 147; Vol. 3 at 53). At the same time she testified that her workload at the hospital was excessive and required her to put in extended amounts of overtime to get the necessary work done. It took 1.5 people, she averred, to replace her when her employment ended. However, the completion time suggested by Ms. Burns for outpatient tests also appeared to be very generous, as were her estimates of

the actual numbers of tests done. Statistics provided by the Hospital directly contradicted Ms. Burns testimony (Exhibits #41, #42) about the number of tests she completed. And, it seems that the temporary replacement positions for outpatient testing filled after her employment amounted to a total of only 19.5 hours per week (Exhibits #17, #18, #56; Vol. 6 at 106).

A specific example of this complementary pattern of exaggeration is in Ms Burns' stance in relation to OHIP revenue for outpatient testing. In a notation made to a letter from the Hospital referring to budget restraints and their impact on the ability of the hospital to provide relief staffing to he Department ((Exhibit #6), Ms Burns stated "I made [approximately] for the hospital $3500 [per month]". In related testimony, she stated that the money she was bringing in to the Hospital was covering her salary (Vol. 1 at 104; Vol. 2 at 171), However, closer scrutiny showed that Ms. Burns herself had prepared a document entitled "Maximum OHIP Billing for the Cardiopulmonary Department" which indicated a possible monthly maximum billing amount of only $2393.00 (Exhibit #55). Further, a December 1989 proposal to the District Health Council prepared by Ms. Burns, indicated an actual billing to OHIP for the previous year of $16,175.00, or $1333.00 per month ((Exhibit #46, at 6). This document also indicated that the OHIP revenue would pay for new equipment during the first six years of funding and only thereafter would help to offset salaries, benefits, equipment repairs etc.

Ms Burns also suggested that "the majority of the work [she did for the hospital] when they needed [her] was for critical care work" (Vol. 2 at 151) on an urgent or emergency basis and that callbacks after hours were necessary. This was directly challenged by Dr. Caughey, who then was and remains, the specialist responsible for respiratory work at the Hospital (Vol. 6 at 135) and by Ms. Mashinter who is the present R.T. at the Hospital (Vol. 7 at 152). Another example of a discrepancy in testimony concerns work done by Ms. Burns preparing a submission to the District Health Council for external funding of the Department. This

submission was completed in late December 1989. Ms. Burns testified that she had never been given the initial funding proposal of 1987 (Exhibit #51) and that she had never asked for it (Vol. 3 at 14, 15). However, a significant proportion of her 1989 submission (Exhibit #45) appears to draw from, or directly quote the 1987 submission.

Similarly, when questioned about conduct that appeared to be contrary to various hospital policies, some of which were revised in March 1989, Ms. Burns testified that, while she had read the Hospital employment policies when she began employment, she had either not received or not consulted the updated policies since, indeed she had "never read the policies again" (Vol. 3 at 63). Yet time and again in her testimony when she discussed disputes or perceived unfairness, she indicated that she had consulted the policies in question and sought to have them used in her favour.

The bearing of these matters on the issues of discrimination and harassment in this case is not direct but it is telling and has several effects. First, the stance implicit in the testimony, even if true, suggests to me a problem in Ms. Burns' management style which supports the Respondents argument that there were independent performance problems related to aspects of her job other than her ability as an R.T.. Secondly, the point of Ms. Burns' denial of receiving the 1987 submission seemed to be to buttress her claim that a performance evaluation conducted in late March 1989 (Exhibit #4) was unexpected and irregular even though it is clearly foreshadowed in this document. Thirdly, and relatedly, it calls into question the credibility of Ms. Burns' version of events. It appeared at times that the cloth was cut to fit. The extent and pattern associated with the "discrepancies" suggests to me that they were more than the effect of the passage of time. Their combined effect is to undermine the reliability of her testimony concerning the course of her employment with the Hospital and the strength of her credibility where there is disputed testimony. I should add that I found the evidence of Ms.

Northmore and Ms. Wilson, in particular, to be candid, detailed, and frequently supported by documentation and contemporaneous records, which in turn, strengthened their testimony concerning points of dispute.

I have no doubt that Ms. Burns felt embattled during the last portion of her employment with the Hospital. I accept that she thought the hospital was treating her unfairly and that she feared for her job. I also accept that her serious illnesses resulting from her handicap may have diminished her capacity to assess situations and respond effectively to them, and indeed to perform her work well. Testimony indicated that Ms. Burns appeared to place a negative construction on many incidents and reach conclusions about them at the time without approaching for clarification or discussion, her supervisor or those directly responsible, which can only have accentuated the difficulties. It is not contested that the quality of Ms. Burns' work as an R.T. was adequate (the probationary performance evaluation completed in January 1990 rates her work as above average, Exhibit #2). However, it is far from correct to suggest that there were no problems with her work, particularly bearing in mind all of the components of the job and the responsibility and professionalism expected of Directors or Department Heads.

Communication was, by all accounts, strained. It appears that the working relationship between Ms. Burns and senior management had completely broken down. Ms. Northmore testified that Ms. Burns would not acknowledge her presence, "she would not speak to me directly, any communication was by memo, she spoke in very derogatory terms about senior management to other staff" (Vol. 5 at 67-68). Ms. Northmore indicated that their working relationship had been tenuous since the meeting of June 30, 1989, in which she had raised performance and programme-related concerns. Ms. Northmore stated that Ms. Burns did not voluntarily inform her about what was happening in the Department (Vol. 5 at 38). Ms. Burns

testified that she "talked to Ms. Northmore about things that were relevant" (Vol. 3 at 101). The Director of Human Resources, Sandra Wilson, testified that "if I met [Ms. Burns] in the hall I would say good morning to her and she refused to answer me; she averted eye contact. We have long corridors and different times when she would see me coming she would either go into a patient room or take an alleyway or something to avoid walking by me in the hall" (Vol. 7 at 43).

Matters came to head in an exchange of correspondence in December 1989. By letter dated December 18, 1989, the Hospital advised Ms. Burns that they had decided that moving Ms. Burns onto part-time was not feasible because of a need for daily attendance, that her attendance was a major concern and that senior management was conducting a review of her employment situation. Ms. Northmore testified that she had changed her mind in relation to part-time work because she felt it would need to be well co-ordinated to work and Ms. Burns' had refused to discuss or cooperate with respect to the proposal (Vol. 5 at 86). At this time, as noted, there was a complete break-down in the working relationships involved. Mr. Lovelock stated that part-time work in this area would be difficult to bring into the hospital because of its impact on physicians and the fact that nurses could not fully perform the functions (Vol. 7 at 11-12). Ms. Burns' herself stated that she did not see how part time could work given the unpredictability of her absences (Vol. 1 at 105. Vol. 3 at 122, 123). The letter of December 18 went on to request Ms. Burns' consent to the release of medical information from her physician, Dr. Heath, to be used in this review. Ms. Burns' granted her consent the following day.

Also on December 19, Ms. Burns wrote two letters to Ms. Northmore. The first responded to the substance of the Hospital's letter and the meeting at which it had been given to her (Exhibit #9). The second requested "a leave of absence which would become effective Jan 19, 1990"

(Exhibit #10) and stated that "[i]n the event that this facility does not feel that I can apply for a medical leave of absence then please accept this letter as my resignation as Director of the Cardiopulmonary Department. This resignation will take effect on January 19, 1990 the same date as the requested medical leave" (Exhibit #10). Ms. Burns did not set out her reasons for seeking the leave of absence. The evidence indicates that no significant tests or surgery were planned or contemplated (e.g. Vol. 4 at 104, 106) and no medical plan was in place (Vol. 3 at 138). I accept that Ms. Burns did not discuss her reasons for seeking the leave of absence with Ms. Northmore or other managers (Vol. 3 at 134).

Dr. Heath by letter dated January 05, 1990 outlined Ms. Burns' medical history and condition and concluded,

> The prognosis for Margo's condition is very difficult to predict. There is no way of telling whether the condition will flare again or settle as it has from 1981 to 1987 without any problems. Unfortunately over the last year Margo has had recurrent attacks of abdominal pain. There does not seem to be any reasonable surgical answer to her problems. ... There are no anticipated procedures surgically and therefore there is no expected time loss from any future planned surgery. Unfortunately I cannot predict whether Margo will lose more than 10 days in the next year (Exhibit #40 at 2).

There was considerable dispute as to which of two possible leave of absence policies were applicable. One policy was the leave of absence -- illness (Exhibit #11). This policy implemented the Hospitals of Ontario Disability Income Plan (the HOODIP plan) which became effective when an employee was ill. Ms. Burns' was very familiar with the provisions and scope of this plan. There was no waiting period or application process; medical support was needed to verify illness and eligibility; time off was paid sick leave. The first 15 weeks of a continuous illness were paid by the Hospital; the following 15 would be paid by UIC. If the employee continued to be ill at the conclusion of 30 weeks, the plan provided for transfer to long term disability and termination of employment.

The other leave of absence was a general, unpaid leave of absence (Exhibit #13). Employees were eligible to apply four weeks in advance for consideration of a leave of absence request. After one year of continuous service, an employee would be eligible for up to 12 intermittent, regular days; after 2 years of continuous service, an employee would be eligible for a period of up to 15 consecutive weeks with the possibility of extensions after reassessment and application in writing.

Ms. Burns testified that she was applying for a paid leave under the leave of absence -- illness, and that she thought that her request for medical leave amounted to the same thing as a physician saying that she needed to be off work on disability (Vol. 1 at 128, 133). However, I am struck by several factors which put this testimony in question. Ms. Burns applied for the leave four weeks in advance. This was not required for the leave of absence -- illness and it was required for the general leave of absence. Ms. Burns' clearly anticipated a 6-8 month period of leave after which point she would return to her job (Vol. 1 at 132). Such a period could have been accommodated by extensions under the general leave of absence, but the leave of absence -- illness contemplated termination at the end of 6 months and movement onto long-term disability. I should also point out that when the Hospital's response came and clearly indicated that she had been refused a leave under the general leave of absence policy, she did not attempt to clarify that she was applying under the other. She did not even raise the point (Vol. 3 at 143).

It was clear that the hospital thought Ms. Burns was applying for a general leave of absence (Vol. 7 at 55, Vol. 5 at 97). Ms. Wilson did state that it was an unusual request (Vol. 7 at 49) and there may have been some lack of clarity on all sides. In any case, I am satisfied that the management team considering the request was alert to the possibility that a leave of absence -- illness might have been an option. In the end, in light of Dr. Heath's report which did not

recommend an extended medical leave (or indicate that tests or procedures which might require it were planned), and the fact that Ms. Burns was then well and not eligible for leave of absence -- illness under HOODIP, it was proper not to begin (or grant) a leave of absence under this policy. I should add that I accept Ms. Northmore's and Ms. Wilson's testimony that Ms. Burns' request for a leave of absence was fully considered notwithstanding the fact that she had not been employed for two years. I also accept that Ms. Northmore let Ms. Burns know this at the time (Vol. 3 at 143). The phrasing in the Hospital's letter of January 9, 1990 (below) is misleading in this respect.

It was in the context of their stated intention to review Ms. Burns' employment status in light of, inter alia, Dr. Heath's report, and Ms. Burns own request for a leave of absence, that the senior management team conducted their deliberations. In testimony, Ms. Northmore outlined the reasons why Ms. Burns' request for a leave of absence was refused. Her testimony was substantially confirmed by Ms. Wilson. The major concern was how to provide the necessary services and continuity during the leave. There were no other R.T.s in the area who were available for part-time or consultative work. I do not accept Ms. Burns' suggestion that an R.T. named "Cindy" was in the area at the time and that the Hospital knew of her availability. I accept that Ms. Wilson checked her personnel files at the time and found no record of this individual (Vol. 7 at 94) and that Ms. Northmore was not aware of her(Vol. 5 at 55). Even on Ms. Burns' evidence, it is very unclear that this individual, who I am prepared to accept had been in some brief contact with Ms. Burns, remained in the area or available to be considered for any short-term position with the Hospital. The management team considered that it would be difficult to recruit an R.T. to come to Bracebridge for a temporary, indefinite period of time with no prospect of permanent work. I believe this assessment was reasonable. At this time there were many R.T. positions advertised across the province, including some 50 jobs per month in Toronto alone. The financial situation of the hospital (that the hospital was in a

deficit situation was not disputed), prevented the Hospital from the prospect of having 2 R.T.'s on staff. Ms. Wilson also noted the costs of advertising (Vol. 7 at 92) for a temporary position, although that would not be a definitive point. It should be noted, however, that the hospital had no external sources of funding for the programme at this time, that the anticipated supporting revenue from OHIP had not been achieved, and that the Hospital was in a significant deficit position during this period.

Ms. Northmore, during cross-examination, amplified further on the discussions. She noted that there was no medical plan. In light of Dr. Heath's medical report, which indicated that nothing was planned to address the problem, the team formed the impression that at the end of the leave of absence, the Hospital would be no further ahead: there was no plan in place for the leave of absence to be successful in relation to Ms. Burns ability to perform the requirements of the position. Ms Northmore also accepted that Ms. Burns' general stace and performance played a role. She stated:

> If we could accommodate her then that was what we wanted to do, but we needed to know what we can accommodate and how we can do that and we could not even speak to each other (Vol. 5 at 168).

Sandra Wilson commented, "we couldn't see any possibility of the situation changing." It should also be noted that Ms. Burns herself had presented the hospital with an either/or situation -- either the leave or she would resign. This stance indicates that it was reasonable for the Hospital to conclude that no other options for accommodation were acceptable. Indeed, no options other than a leave of absence -- illness were discussed at the hearing short of hiring a second, full-time, permanent R.T. into the Department.

On January 9, 1990, Ms. Northmore delivered to Ms. Burns a letter from the Hospital which stated:

> In acknowledgement of your request for a leave of absence due to health reasons, hospital policy requires than employee complete two years of service before a request for a leave of absence is considered.

> We are therefore accepting your resignation effective January 19, 1990 with the last day of work being today, January 09.

Ms. Burns worked January 09 and later, was helped to move out of her office by Ms. Northmore. The next day, she sent a letter by registered mail (Exhibit #14) outlining matters discussed on January 09, stating that she accepted the decision of the Hospital "although difficult to swallow" and expressing her various concerns about the process involved. She also wrote a letter that day to the Chairman of the Hospital Board which indicated, among other things, that she planned to go ahead with a formal complaint to the Commission (Exhibit #15). As indicated above, her initial formal complaint to the Commission followed in June 1990.

Following the end of her employment with the Hospital, Ms. Burns took a contract position from February 2 to June 1, 1990 with the United Nations in Saudi Arabia and from October 1 to December 31, 1990 with the Government of Saskatchewan at the Moose Jaw Hospital. She returned to Ottawa and worked for 18 months at Algonquin College and on summer contracts with the Department of National Defence Hospital. She currently works part-time at a hospital in Ottawa.

Issues Arising for Determination

With this general outline of events, it is possible to state the issues which arise for determination. This case raises the broad issues of whether the Respondents discriminated against the Complainant or harassed her in the workplace on the basis of handicap in contravention of the Code. At the outset of the hearing, I was informed that the parties were agreed that Ms. Burns' medical condition amounted to a handicap as defined in s. 10 of the Code.

The Code provides a right to be free from discrimination in employment because of handicap (ss. 5, 9) but provides in section 17:

> (1) A right of a person under this Act is not infringed for the reason only that the person is incapable of performing or fulfilling the essential duties or requirements attending the exercise of the rights because of handicap.
> (2) The Commission, a board of inquiry or a court shall not find a person incapable unless it is satisfied that the needs of the person cannot be accommodated without undue hardship on the person responsible for accommodating those needs, considering the cost, outside sources of funding, if any, and health and safety requirements, if any.

The basic structure of inquiries in relation to discrimination on the basis of handicap seems to be as follows. A prima facie case of discrimination must first be established by the Commission. Once a prima facie case has been established, the onus shifts to the respondent to prove a defence permitted by Code, (not asserted here) or to establish that the complaintant was incapable of performing or fulfilling the essential duties or requirements of the job and hence, pursuant to section 17, that there was no infringement of the Code.

With this general framework in mind, the particular issues for determination include:

1. Did the Respondents harass the Complainant in the workplace because of her handicap?

2. Did the employment of the Complainant with the Hospital cease as a result of her handicap? ie. is there a prima facie case of discrimination?

3. If there was prima facie discrimination, was the complainant capable of performing or fulfilling the essential duties or requirements of her job nothwithstanding her handicap?

   i. was Ms. Burns, because of her handicap, incapable of performing duties or requirements that were essential to the job?

ii. could the Respondents have accommodated Ms. Burns in relation to those essential duties and requirements without causing undue hardship to the Hospital?

4. Could the Hospital's policy, which required two years of service before employees were eligible to receive a general leave of absence, be considered to have an adverse impact on persons suffering from a handicap? If so, did the hospital discharge its obligation to attempt to accommodate Ms. Burns in relation to this policy?

5. If it is found that the Respondents did discriminate against Ms. Burns in her employment or harass her in the workplace because of handicap, what is the appropriate remedy?

Analysis

Issue 1: Did the Respondents harass the Complainant in the workplace because of her handicap?

The Code defines harassment in section 10, as "engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome."

Generally, allegations of harassment involve some suggestion that the complainant was subjected to conduct (or comment) that was "offensive" (e.g. a developmentally handicapped employee being repeatedly called a "dummy": Boehm v. National System of Baking (1987), 8 C.H.R.R. D/4110 Ont. Bd. of Inq.) or which led to embarrassment, intimidation or fright and would, or should, be known to be annoying or distressing to the recipient. I take it to be self-evident that, in some human rights sense, the conduct in question must be inappropriate or

wrongheaded and be directed personally at the complainant. Truth or good faith efforts to manage a situation may be unwelcome, even distressing, but that does not make them harassment.

In the context of handicap, the enquiry is whether Respondents engaged in a course of vexatious conduct against Ms. Burns because of her handicap that was known or ought reasonably have been known to them as being unwelcome. Mr. Abrahams, for the Commission, submitted that there were at least eight instances of conduct which, separately and cumulatively, constituted such harassment against Ms. Burns. I will address them in turn.

Threats of Termination

One of the instances of alleged harassment was that the Respondents "constantly threatened Ms. Burns with termination as a result of her illness." In support of this allegation were letters or memos written by Ms. Northmore requiring Ms. Burns to conform to the hospital average for sick time and making reference to movement to part time status or termination as possible outcomes if the situation could not be managed satisfactorily. Yet, these were formal communications which related to a serious problem which both parties needed to attend to and they were not ad hoc or mean-spirited attempts to intimidate the Complainant. Ms. Northmore commented (Vol. 6 at 82) "at no time did I want to terminate her, she was skilled in her position, but we needed to be able to provide continuous high quality patient care and this is what I wanted to do." I do not accept that these matters amounted to harassment. Ms. Burns' refusal to address the problems may have increased her distress when Ms. Northmore insisted on the matter, but this did not constitute harassment.

The March Programme Evaluation

Nevertheless, Ms. Burns' clearly thought that Ms. Northmore was trying to terminate her employment and this may well have coloured her perceptions of later events. In a handwritten summation provided to the Commission she wrote, in reference to a March programme/performance evaluation, "I believe that this form was the start of Mrs. Northmore's determined effort to have me removed from my position" (Exhibit #39). This evaluation was the basis of a second allegation of harassment.

Around March 23 1989, just prior to Easter, a form entitled "Program Evaluation" for the "Cardiopulmonary Services" Program, was circulated by Ms. Northmore to Dr. Caughey and the Head Nurses (Vol. 5 at 18). The indicated purpose was "to evaluate the effectiveness of the respiratory service in meeting the established goals". Various questions were asked on the form concerning availability of the R.T., monitoring of patients by the R.T., and provision of inservice education. The contentious questions were number 5, "Has the Respiratory therapist participated in Traumas and codes effectively?"; number 6, "Does the Respiratory therapist appear competent and efficient in carrying out her responsibilities?"; and number 7, "Are there functions not presently being done that the Respiratory therapist could do within her area of expertise" (Exhibit #4). Ms. Burns and Ms. Northmore agreed only that they had discussed some form of evaluation of the program that week (likely March 21), and that it related in some way to the external funding submissions.

Ms. Burns testified that she had suggested that the respiratory services be evaluated separately from the cardiac testing services (Vol. 1 at 50), that she thought that the evaluations would involve standard forms from the Ministry of Health, and that Ms. Northmore had said they would work on the forms and new submission together when Ms. Northmore returned from a vacation scheduled after Easter. On March 22, Ms. Burns herself "booked off" for an extended

Easter break using overtime and a "floating statutory holiday". She testified that when she returned, she discovered that Ms. Northmore had circulated the form when Ms. Merkley showed it to her.

I accept that Ms. Burns was upset, even outraged at this turn of events. She contacted the C.E.O. and the Director of Human Resources to express her concerns that this had occurred and was irregular and to try to stop the process (Vol. 1 at 62 and Vol. 3 at 10). She discussed it with the nurses and physicians. She testified that Dr. Caughey was upset and, in notes to the Commission (Exhibit #39) wrote that Dr. Heath was furious about the form. She testified that she objected so strongly because the form was different from what had been discussed (Vol. 1 at 61) and had been circulated without her permission (Vol. 3 at 31) to Head Nurses, who were below her in the Hospital hierarchy. In her view, it was improper that they evaluate her (Vol. 3 at 27). She also objected that the evaluation focused only on respiratory services which were a problem area, that it was not a programme evaluation but an evaluation of her as an individual and her ability to work as an R.T. (Vol. 1 at 61), and that nurses were not, in any case, qualified to evaluate respiratory matters. This last point was asserted despite her earlier testimony that the nurses were able to do 90 per cent of the job she did at the Hospital (Vol. 3 at 21).

She suggested that Ms. Northmore should have conducted an audit of patient charts or a questionnaire of patients to obtain the information in a less offensive manner (Vol. 3 at 30). She stated that she did not consider waiting until Ms. Northmore returned from vacation to discuss the matter (Vol. 3 at 10), and that she never discussed her objections or upset directly with Ms. Northmore (Vol. 1 at 63).

Ms. Northmore testified that she had been telephoned at home during her vacation by a nurse who told her that "all hell had broken loose" when Ms. Burns had become aware of the

circulation of the evaluation form (Vol. 5 at 21). She returned from vacation to "alot of discussion about the evaluation and she was informed that Margo was very upset about it having been given out". (Vol. 5 at 20). By this time, Ms. Burns was on an extended sick leave. Taking Ms. Northmore's response to the objections in turn, she pointed out that the nature of the evaluation and its timing were indicated in the 1987 funding submission (Vol. 5 at 19) and that a six-month evaluation had been discussed in October 1988. She also noted that it was within her area of responsibility to perform the evaluation and that, when she had gone to speak with Ms. Burns prior to circulating the form, she had found that Ms. Burns had booked the time off without informing her. Ms. Burns could not herself remember if she had informed Ms. Northmore (Vol. 3 at 6). Ms. Northmore decided to put the form out anyway (Vol. 5 at 18).

She explained that, whilst technically correct that Head Nurses did not have Department Head status, they were considered equivalent to Department Heads in the management hierarchy of the hospital (Vol. 5 at 146). Sandra Wilson, Director of Human Resources, confirmed this information (Vol. 7 at 23; see also Vol. 6 at 137, Vol. 7 at 144). I note that Ms. Burns herself suggested a separate focus on respiratory from cardiac services. Ms. Northmore testified that the questionnaire was the only way to obtain the information and it was sought from people who worked with Ms. Burns and who had a basic familiarity with respiratory needs. I also note that when there is a one-person department, questions about delivery of services will necessarily relate back personally to that one person.

Ms. Mashinter, the present R.T. at the Hospital, expressed her opinion that the questions were fair (Vol. 7 at 144). Dr. Caughey testified that he told Ms. Burns that the questions were necessary (Vol. 6 at 139) and Dr. Heath testified only that he recalled that Ms. Burns had some concerns with the form (Vol. 4 at 100). Ms. Northmore indicated that she did not

consider that she was treating this programme differently from other programmes. It was a new programme and she has since evaluated another new department in a similar manner (Vol. 5 at 142, 158). I also note that Ms. Northmore decided not to pursue responses to the evaluation form or to proceed with evaluation of the cardiac services when she returned and realized that Ms. Burns was upset, and not available for discussion because of her illness. She prepared an evaluation (Exhibit #53) based on information she could gather independently.

It is my view that, in an ideal world the form would have been confirmed prior to circulation. Nevertheless the problem was compounded by Ms. Burns' own actions in not discussing her impending vacation with Ms. Northmore and by the manner of her response to the form. It is also my view that the questions, while not perfect, were fair (Ms. Northmore herself commented that, in hindsight, it could have been worded differently: Vol. 5 at 145), and that the distribution of the form to Dr. Caughey and the Head Nurses was appropriate. I find that this evaluation was not an instance of harassment. Ms. Burns adjusted her own testimony on this point when she when commented that "it began a long term problem that eventually resulted in harassment" (Vol. 3 at 35). However, I find that while it may have suggested problems, it did not form part of a pattern of harassment against Ms. Burns by Ms. Northmore or the Hospital.

The Requirement to Give Two Days Notice of Return to Work

A third allegation of harassment was that the Hospital required Ms. Burns to give two days notice of return to work after an absence related to illness. This requirement was put in writing on September 14 (Exhibit #5) and Ms. Burns stated that she considered this to be harassment because no-one else in the Hospital had to do this and it was not part of Hospital policy (Vol. [illegible]t 75-77). She considered it to be an unfair requirement (Vol: 3 at 74). There is some

discrepancy about which policy Ms. Burns consulted to reach her conclusions. Ms. Burns indicated that she consulted Exhibit #16 which relates to pay schedules. It is true that this policy says nothing about notice for return to work. Ms. Burns suggested that she was also concerned at the September 14 meeting that she wasn't going to get her correct pay level (Vol 3 at 74) and I believe that she consulted that policy in that regard. Mr. Hickman brought the correct policy to her attention (Exhibit #11) which states "When an employee is able to return to work, the employee must notify the Department Head in adequate time to prevent the duplication of staffing". In response, Ms. Burns temporized. It was a revised policy. She didn't have this policy (Vol. 3 at 75), and anyway, "it doesn't say that you have to give two days notice" (Vol. 3 at 75). This last point was indeed notated at some point by Ms. Burns on her copy of the relevant policy.

Ms Northmore and Ms. Wilson commented that the policy is flexible and is worked out in individual cases. They each stated that they outlined their concerns about "over-scheduling" or duplication of staffing and the need to avoid unfairness to Katherine Galarneau who was often scheduled in relief of Ms. Burns and who could find herself without work or pay if Ms. Burns returned without notice (e.g., Vol. 5 at 50, Vol 7 at 25).

I have already commented on Ms. Burns' testimony concerning her knowledge and use of policies. I consider that her testimony in this area is neither credible, nor justifiable. I find that the two day notification of return to work was consistent with hospital policy, was reasonable in the circumstances, and was not any form of harassment of Ms. Burns.

The Use of Overtime for Sick Time and the Reinstatement of the Sick Bank.

The fourth and fifth allegations of harassment are usefully considered together as they are so closely connected. The allegations are that Ms. Burns was harassed when the Hospital refused to allow her to use overtime to replace two periods of sick time in July when this practice was allowed at the hospital. It is also asserted that Ms. Burns was harassed when the Hospital did not reinstate the appropriate allowance of sick time (her sick bank) pursuant to the HOODIP when she was hospitalized with a new illness resulting from the motor vehicle accident in August. The HOODIP plan stipulates that the full allowance of 75 days of sick time is to be reinstated when there is a new illness. Where an employee has been back at work for three weeks after an period of illness, the full 75 days are also to be reinstated (Exhibit #31).

The basic facts are as follows. Ms. Burns was ill on June 22 and 23. This was at least her fourth illness for the year. She submitted her time sheet for those days indicating sick time. She was ill again for a full week beginning July 3. Ms. Northmore submitted Ms. Burns' time sheet indicating sick time for those days. At some later point, Ms. Burns changed her time sheets for both periods to indicate that the days should be recorded and paid as overtime not as sick time. Ms. Burns testified that there "was a policy in place that you could use overtime and vacation time in place of sick time and because I had so much overtime, I decided to use it up" (Vol. 1 at 70). Yet this was not a policy and Hospital witnesses were not aware of any practice in this regard although the payroll clerk seemed familiar with such an arrangement. The significance of substituting overtime for sick time is twofold: the rate of pay for overtime was 100 per cent rather than 66 per cent on sick time, and, perhaps more importantly, using overtime prevented a discontinuity in the three week qualifying period for refreshment of the 75 day sick bank. The acceptance of the June 23 and 24 period would have given Ms. Burns three weeks of continuous work.

Ms. Burns was again ill between July 13 and August 4. The computer print out of her pay slip on August 13 indicated that she had 56 days of sick time left in her sick bank. Joyce Roberts,

the payroll clerk at the time, testified that Ms. Northmore and Ms. Wilson came to the payroll office at some point and obtained the time sheet that Ms. Burns had changed to indicate overtime. Ms. Roberts testified that they took it away and brought it back with changes which she then input to the payroll computer (Vol. 4 at 112). Between August 21 and September 8, Ms. Burns was hospitalized and away from work as a result of a new illness arising from a motor vehicle accident. Ms. Northmore submitted her time sheet for the first week indicating that this was a new illness. Ms. Burns' pay slip of August 27 indicated that only 9.46 days were left in her sick bank, a change of 46.54 days in a two week period. She received a letter during her hospitalization for the motor vehicle accident advising her that her sick bank would be exhausted by September 08 and enclosing UIC application forms.

Ms. Burns returned to work on September 13 (after submitting September 11 and 12 as overtime) and her pay slips continued to indicate that zero days were available in her sick bank. Ms. Burns was convinced that the Hospital was refusing to reinstate of her sick bank, and, after consulting with the Commission, she called the OHA on October 9, to request their assistance. The OHA called the Hospital (Ms. Wilson) and Ms. Burns on October 10. At this time, it was confirmed that 75 sick days were available to Ms. Burns.

On the face of it, something might appear to be afoul in this chronology. Mr. Abrahams, for the Commission certainly made the most of appearances in his submissions in support of these incidents as harassment submitting:

> It's odd then, in my view, for Ms. Sandra Wilson to make such a scrutiny of this complainant's sick bank and change it on her own accord, change it from 56 to 9, and not... say anything to this complainant about it... We heard evidence that the complainant did not receive her reinstatement of 75 days for this new illness and we heard evidence that the computer would automatically kick in... The point of the matter is that Ms. Burns had to go to extraordinary lengths to get back her 75 day reinstatement that was due to her... it is strange, let me say, that it took over six weeks and a call to OHA before someone could get back her 75 days, and when you put it together with the fact that they took it upon themselves to change her available sick days and had submitted her time sheet, well, the evidence is there (Vol. 8 at 13, 14, 17).

The question for me, of course, is to assess what evidence is in fact there.

I heard a great deal of evidence about what may or may not have happened. Various calculations as to depletion rates of the sick bank were modelled and hinged on various assumptions. In the end, the records themselves (most particularly the attendance record, Exhibit #35 and the pay slips, Exhibits #63, 64 and 64), and the testimony of Ms. Wilson on key points, made it possible to put together a clear picture of what actually occurred.

An important record is the time slip of August 13 which indicated that 56 days were available in Ms. Burns' sick bank (Exhibit #63) and thus, that only 19 days had been taken as accumulating sick time. Where did this figure come from? Ms. Burns had been off sick for approximately 40 days between the end of March and the middle of June and she was again ill for 19 undisputed days up until August 04. As such, this figure of 56 available days is only explicable if her sick bank had been refreshed. Two possibilities for this refreshment exist: either the time on June 23 and 24 were input as overtime (giving Ms. Burns three weeks continuous work) or the days went in as sick time together with an indication that they were a new illness. The difference matters.

Ms. Burns' explanation is that the dates went in as overtime and were subsequently changed back to sick time and that that change accounted for the consequent sudden change in her sick bank. Ms. Burns also testified that the July dates were also switched back to sick time.

But this explanation does not fit with the figures. If the June and July days went in as overtime rather than sick time, her pay slip for August 13 would have shown 58 days. It showed 56. If all the "overtime dates" were changed to sick time and as a continuing illness, her pay slip on

August 27 should have shown 4.46 days of available sick time. It showed 9.46 days. Ms. Burns' explanation is not correct.

The key to unravelling the mystery is in Ms. Wilson's statement that:

> there should not have been 56 available days there, the computer -- or the payroll I believe at some time earlier, and I honestly don't know the date but I could get the whole print out and then show it to you, where it had been entered as a new illness and she had reverted to a lot more days than she should have. So therefore Margo should have been aware that there was an incorrect figure (Vol. 7 at 100).

Ms. Wilson expressed her recollection that June 23 and 24 were paid as sick time and she indicated that she had intervened to correct the payroll clerk's error in entering those days as a new illness.

What happens to the figures if these June 23, 24 are paid as sick time and as a new illness? If one excludes July 3-7 which Ms. Burns changed to be overtime, 19 days are recorded as sick time from June 22 to August 13 leaving 56 available sick days at the end of the period. This matches the pay slip exactly and supports Ms. Wilson's testimony. What happens if, after the August 13 pay slip, the change indicated by Ms. Wilson is made and there the computer records the illness as a "continuing" illness? The sick bank depletes from March 30 until August 27 during which there were no three week periods of work. Again leaving out the July 3-7 period, 65.54 days are used (the fractions arising from the modified work period), and 9.46 days are left. This matches the August 27 pay slip and again supports Ms. Wilson's testimony.

Tortuous as the figures seem, the tell the following story. As a result of an error by payroll, the June 23 and 24 dates were initially entered as a new illness. Ms. Wilson became aware of the likelihood of an error and intervened to correct it by resetting June 23 and 24 as a "continuing illness". This intervention likely occurred sometime between August 13 and

August 27. At no point were these days entered as overtime (or changed back to sick time from overtime). The July 3-7 dates were changed by payroll as requested by Ms. Burns, to record as overtime and these dates were not changed back by management. Ms. Wilson made a telling point when she agreed with a question directed to her by Mr. Hickman that the mistakes made by payroll may have been created as a result of Ms. Burns' changing her time sheet (Vol. 7 at 132).

Accordingly, I do not find the factual basis is laid for the allegation that Ms. Burns was harassed by the Hospital refusing to allow her to replace sick time with overtime. I should add that I would not have found anything particularly wrong even if this had in fact occurred. The only hospital policy which had permitted overtime to be substituted for illness related to the first two days of the fourth illness. The rationale for this policy was that HOODIP did not cover the first two days of the fourth illness. When a change was made in the industry and the Hospital decided that it would pay those first two days, the policy changed effective April 1989. As a Department Head, Ms. Burns was responsible for knowing Hospital policy. Ms. Wilson and Ms. Northmore pointed it out to her on September 14 when the matter of overtime was discussed. The changes made by Ms. Burns to her time sheets were, simply put, irregular. For completeness I should add that Ms. Burns herself appeared at some points in her testimony to state that this matter was not an instance of harassment (e.g. Vol. 3 at 66).

If it is accepted that the pay slip of August 27 was an accurate statement of continuing depletion of the sick bank from recurring illness, there is still the problem of what happened in relation to the time taken from August 21-September 8 as a result of Ms. Burns' hospitalization after the motor vehicle accident. As noted, the August 27 pay slip (at the end of the first week of the hospitalization) showed only 9.46 days remaining and it was followed by letter from the office of the Director of Human Resources notifying Ms. Burns' that her sick

bank would be exhausted as of September 08. Ms. Burns' pay slip for September 10 indicates an availability of zero sick days. The obvious implication is that this illness was incorrectly treated as a continuing illness.

However, it is clearly indicated on the time sheet submitted by Ms. Northmore for this period (Exhibit #38) that this time should be entered as a new illness. This, in itself, militates against a finding of harassment in this regard. It is true that the sick bank should have been reset. It is also true that clear instructions to ensure that it was reset were given by Ms. Northmore. The fact that the 75 day allotment was not immediately reinstated strongly suggests that an error was made by the payroll clerk in failing to input the "N" indicated in the relevant column of the time sheet. Accordingly, the sick bank continued to deplete.

I accept that Ms. Burns talked with John Fredericks, the Director of Finance, about the matter in early September, when she received the letter indicating that her sick bank was all but depleted. However, I find it inexplicable that Ms. Burns did not raise the matter with either Ms. Northmore or Ms. Wilson upon her return to work in mid-September, especially all three met on September 14. I accept that is highly unlikely that either Ms. Northmore or Ms. Wilson knew there was a potential problem with the sick bank arising from the motor vehicle accident hospitalization (see e.g. Vol. 7 at 119). Indeed, Ms. Wilson was not immediately aware of the circumstances of Ms. Burns' most recent absence (Vol. 7 at 114). The fact that Ms. Burns had met with the Commission in Ottawa on September 12 may suggest that her stance in this matter was already set.

After her return to work in September, Ms. Burns accumulated (more than) three weeks of continuous work time. However, her available sick bank continued to be indicated as zero. Was the Hospital refusing to reinstate her sick bank as an instance or part of a pattern of

harassing her because of her handicap? Was it true that Ms. Burns had to go to "extraordinary lengths" to have her sick bank reinstated? Again the evidence suggests not.

Ms. Wilson testified that it takes two complete pay periods for the computer to read a three week return to work and to "reset" the sick bank, and a further pay period for this information to be reflected on the computer print out on a pay slip. It would not be unusual then, for a full six weeks to elapse before the print out reflected the actual status of the sick bank. However, Ms. Wilson testified that she could go into the computer and verify the actual status of the sick bank at any time and obtain an immediate print out if necessary. She stated that the effective date for the sick bank renewal would be as of the end of the third week back to work (Vol. 7 at 117, 120-122) even though this would not be reflected on the pay slip immediately. When Ms. Wilson received the telephone call from the OHA and checked the problem she found that the sick bank had in fact reverted to 75 days. Accordingly there was no need for her to reset the sick bank or identify and correct earlier errors. In fact, I think it quite likely that the possibility of an error by the payroll clerk in failing to input the illness as a "new" illness was not discovered until a later review.

It follows, then, that the hospital was not in fact refusing to reinstate Ms. Burns' sick bank generally or in relation to the motor vehicle illness and the factual basis for this allegation of harassment is not laid.

Ms. Burns took no steps to clarify the situation until she contacted the OHA and felt herself to be in an adversarial relation with the Hospital in relation to the matter. Ms. Burns did not address her concerns directly to either Ms. Wilson or Ms. Northmore (Vol. 3 at 95, Vol. 6 at 49) and had she done so, a great deal of distress and anxiety on her part may have been voided. Whilst it is true that Ms. Burns may well have felt herself to disadvantaged in the

situation which was clearly moving into crisis, the pattern on her part of non-communication and non-cooperation with those directly involved, and her certainty that unfairness was being done, is too noticeable to escape comment.

Other allegations

The three remaining submissions by the Commission are that the Hospital harassed Ms. Burns when she was asked if she had been honest in her application for employment, when she was advised that she would not have been hired into her position if the hospital had known of her condition previously, and when she was advised that the Hospital was withdrawing the option of part-time work (Vol. 8 at 3-4). I will deal with each allegation in turn.

Ms. Burns testified that her honesty in her employment application, about her medical condition, was raised in a September 22 meeting with Ms. Northmore and Mr. Frederick and again at an October 13 meeting with Ms. Northmore and Mr. Lovelock. She alleged that it was stated in the October meeting that had she been honest the Hospital would have been able to accommodate her. Mr. Lovelock stated that he did not recall being in a meeting with Ms. Burns at which her honesty was discussed (Vol. 7 at 15). Mr. Fredericks could not recall the meeting of September 22 in his oral testimony but wrote in his witness statement (Exhibit #58) that "he did not recall hearing anyone asking Ms. Burns if she had been honest about her past health on her application form when hired." The question was not directed to Ms. Northmore and Mr. Hickman submitted, which I accept, that the rules of evidence would direct that it must be assumed that she would deny the matter (Vol. 7 at 18). Both Mr. Fredericks and Mr. Lovelock agreed that the matter was discussed in management meetings but not with Ms. Burns present (Vol. 7 at 15).

I should add that Mr. Abrahams may have gone too far when he submitted that when Ms. Burns applied for the job that she did not know about her condition of pancreas divisum (Vol. 8 at 30). The medical history suggests an initial diagnosis of this condition in June 1987.

Be that as it may, I am not prepared to accept the Complainant's evidence that her honesty was challenged in the manner alleged and do not find that she was harassed in this manner. I think it more likely that it was stated that had she co-operated with management, it might have been easier to accommodate her situation.

I also accept that it was said to her that if she were a nurse or lab technician it would have been easier to replace her (see e.g. Vol. 7 at 7). I think this matter goes to the issue of accommodation and is a matter of law and the assessment of the Hospital's obligations in that regard. That Ms. Burns perceived it as harassment (even though she admitted it was true: Vol. 3 at 117) rather than as a valid management concern or matter of legal debate may well have compounded her distress. However, I am not prepared to find it amounted to harassment of the Complainant within the meaning of the Code.

Finally, is the issue of the withdrawal of the option of reverting to part-time status. I think that this matter also goes to efforts to accommodate and will consider it more fully below. However, it is my opinion that the withdrawal of the part-time option was not in itself an act of harassment. I accept that the option of part-time was presented as initial management thinking about how best to control the impact of Ms. Burns' absences and that it was in no way directed to harassing her. I accept the evidence of Ms. Northmore and others that Ms. Burns became very upset and increasingly hostile whenever the matter was raised. It is clear that Ms. Burns felt that the option was being forced upon her and that she considered it unworkable. As noted above, I do not accept that Ms. Burns was willing to accept part-time

work on any kind of positive basis. In this context, then, withdrawing the part-time option cannot be considered harassment.

In his submissions, Mr. Abrahams linked the withdrawal of the part-time work to a more general argument that it was harassing to advise Ms. Burns that the hospital could not keep her on, even on a part-time basis. I infer that his reference is to the Hospital's letter of December 18, which indicated that part-time work was not feasible and a review of Ms. Burns' employment was being conducted by senior management. Again, the withdrawal of the part-time option was consistent with Ms. Burns' own expressed views. Ms. Burns was not told at this time that her employment could not be continued. It is my view that management were fulfilling their obligation to conduct a full and informed review and assessment before reaching employment-related decisions. It follows that I find that this did not constitute harassment.

After what I concede is a somewhat exhaustive review of the allegations of harassment, my conclusion on Issue 1 is that the Complainant was not harassed in the workplace because of handicap.

Issue 2: Did the employment of the Complainant with the Hospital cease as a result of her handicap? ie. is there a prima facie case of discrimination?

Between December 18, 1989 and January 09, 1990, senior management reviewed the status of Ms. Burns' employment and her application for a leave of absence. When they decided not to grant the leave of absence and accepted her resignation, they knew that the effect would be that Ms. Burns' employment with the hospital would cease.

In testimony concerning the Hospital's decisions concerning Ms. Burns' employment, Ms. Northmore accepted the Commission's suggestion that the offer of part-time was withdrawn,

and the request for the leave of absence was rejected, because of Ms. Burns' absences related to her illnesses. Ms. Wilson agreed that concerns about the unpredictability of Ms. Burns' illnesses and the prognosis for her condition were part of management discussion and played a role in the decision not to grant the requested leave of absence (Vol. 95-97).

In Ontario Human Rights Commission and Gaines Pet Foods (1993), 16 O.R. (3d) 290 at 293, the Ontario Divisional Court stated, "the law is clear that the prohibitive ground of discrimination need not be the only reason for the action taken, so long as it forms one of the reasons."

I accept this principle and conclude that Ms. Burns' handicap was one of the underlying reasons for decisions taken by the Hospital which lead to the end of her employment. As such a threshold prima facie case of discrimination contrary to the Code has been established.

Issue 3: If there was prima facie discrimination, was the Complainant capable of performing or fulfilling the essential duties or requirements of her job notwithstanding her handicap?

The Law

As indicated above, section 17 of the Code establishes that where a person is incapable of performing or fulfilling essential duties or requirements because of handicap and, as a result they are, for example, not hired or are released from employment, their rights under the Code are not infringed. This modification of the scope of section 5 rights to be free from discrimination in employment on the basis of handicap, requires respondents to establish two things. The first is that the area in which they claim incapability is essential. They must also establish on an objective basis that the complainant was incapable of doing his or her job without accommodation. Secondly, a respondent must establish that they could not accommodate the needs of the complainant without creating undue hardship.

In my view, the Code envisages a situation where "but for" the handicap, a complainant would be able to perform satisfactorily and that they have "needs" related to their handicap which, if met, would actually enable the person to perform the work. (Bonner v. Ontario (Ministry of Health) (1992), 16 C.H.R.R. D/485 at D/496). The purpose of the Code seems to be to support the inclusion and integration of persons with disabilities into the workplace. But, as stated in Chamberlin v. Stirling Honda (1989), 11 C.H.R.R. D/110 at D/116:

> the Code does not ignore the fact that certain handicaps can negatively impact on an individual's ability to perform certain types of work. If a person is unable to adequately perform certain particular types of job because of a handicap, the Code does not entitle that person to employment in the job. What the Code does

> do is ensure that persons with a handicap are not discriminated against with respect to jobs they are capable of performing... circumstances may exist where a handicapped person is capable of performing the essential functions of a position provided some reasonable steps are taken to accommodate the handicap.

Thus, the emphasis is on taking steps that will lead to the person with a disability being able to perform the job.

The Duty to Accommodate

The essence of the "duty to accommodate" incorporated into section 17 of the Code is that an obligation is placed on employers to look beyond what would be most convenient for them. They must be conscientious and even creative in assessing whether it would be possible to integrate a person with a disability into a particular position. Employers must take substantial or meaningful steps to accommodate the requirements of a complainant (Gohm v. Domtar (No. 4), (1990), 12 C.H.R.R. D/161 at D/175). The limit on this duty is the point of "undue hardship" to the employer; it has been said often enough that the legislation assumes that employers might need to absorb some degree of "due" hardship, including some additional cost or expense.

An employer must make an effort to assess whether an employee with a disability is capable of effectively performing the essential requirements of the position. In Cameron v. Nel Gor Castle Nursing Home (1984), 5 C.H.R.R. D/2170 at D/2180, Professor Cumming stated: "a corollary is to require an employer to make a decision respecting employment based upon a fair and accurate assessment of her true ability and not based upon a stereotype or misconception about her handicap." In Belliveau v. Steel Co. of Canada (1988), 9 C.H.R.R. D/5250 at D/5251, he repeated this view. David Lepofsky in "The Duty to Accommodate: A

Purposive Approach" 1 Can. Lab. L.J. 1 at 13 puts it well when he states "One requisite step is for the employer ...to undertake a thorough and adequate process of inquiry and deliberations on the request for accommodation... including a thorough exploration of the possibilities." Lepofsky suggests that the inquiry into the adequacy of the deliberative process should consider who was involved, what options were considered, whether sufficient effort was employed to solicit the views of the worker, and whether a good faith attitude was adopted. He suggests that care be taken to assess whether the respondent has exaggerated the costs or adverse consequences or is attempting to rely on hardships that were never considered at the time (Ibid. at 14-16).

The Duty of the Employee

In O'Malley v. Simpson Sears Ltd. (1985), 7 C.H.R.R. D/3102 (S.C.C.) at D/3107, Mr. Justice McIntyre pointed out that an employee must themself participate in the process of exploring accommodation and may be required to make some concessions:

> The employer must take reasonable steps toward that end which may or may not result in full accommodation. Where such reasonable steps, however, do not fully reach the desired end, the complainant, in the absence of some accommodating steps on his own part such as acceptance of part-time work, must either sacrifice his religious principles or his employment.

The Supreme Court has accepted that a complainant should attempt to accommodate his or her employer. This point was adverted to in Central Alberta Dairy Pool v. Alberta (Human Rights Commission), (1990), 12 C.H.R.R. D/417 at D/421 where an employee had requested time off work for religious observance. In Central Okanagan School District No. 23 v. Renaud, [1992] 2 S.C.R. 970, the court commented, again in the context of accommodation of religious belief:

> The search for accommodation is a multi-party inquiry. The complainant also has a duty to assist in securing an appropriate accommodation and his or her

> conduct must therefore be considered in determining whether the duty to accommodate has been fulfilled. When an employer has initiated a proposal that is reasonable and would, if implemented, fulfill the duty to accommodate, the complainant has a duty to facilitate the implementation of the proposal. If the complainant fails to take reasonable steps and causes the proposal to founder, the complaint will be dismissed. The complainant is also obligated to accept reasonable accommodation and the employer's duty is discharged if a proposal that would be reasonable in all the circumstances is turned down (Headnote; see text at 990-991)

A further aspect of the employee's responsibilities is outlined in Belliveau, supra. In this Ontario Board of Inquiry case, an employee who had been off work for some time received an unexpected medical clearance to return to his job as a coal handler. This work involved above the shoulder lifting and Mr. Belliveau had sustained a shoulder injury in the course of his work. Despite the medical clearance, the employer remained uncertain that he could perform the job duties. In his decision, Professor Cumming concluded that the employer had not taken all the steps appropriate to determine the issue of Mr. Belliveau's actual fitness but he limited damages to a nominal sum in light of the circumstances, which included lack of cooperation by the complainant in clarifying the situation. He commented at D/5255:

> In my opinion, a disabled person in Mr. Belliveau's position must effectively communicate that he clearly believes he is capable of doing the essential requirements of the job. An employee cannot simply remain silent when decisions are made in good faith that affect his interest, and say later that the company failed to take initiatives. Mr. Belliveau was the person mainly responsible for not quickly sorting out and clarifying his medical situation following upon the June 6 rejection of his return to regular duties by Stelco...
>
> In my view, the primary responsibility ... was upon Mr. Belliveau to clarify the medical situation. An employer has certain, limited means of acquiring the necessary information through an assessment but a main input must be the cooperation of the employee and the relevant information the employee has at his disposal. There is a responsibility upon an employee to make available all relevant information within the employee's control.

These statements make it clear that employees/complainants have a duty to assist in securing appropriate accommodation of their needs. They should make their needs known to the employer and provide all relevant information within their control concerning the situation.

Where possible, they should promptly clarify any misunderstandings: an employee cannot simply remain silent when decisions are made in good faith that affect his or her interests. They have a duty to facilitate reasonable proposals for accommodation and may be required to take accommodating steps of their own even though the primary duty to accommodate and the onus to establish that the requisite considerations were made, rests on the employer (O'Malley, supra at D/3108).

The Limits of Accommodation: Effective Accommodation Must be Possible and Undue Hardship Need Not be Sustained

As indicated above, the purpose of accommodation is to create conditions or to take steps to enable a handicapped person to perform the essential functions of a position: "the Code does not give a person a right to a position he [sic] cannot effectively perform. Instead it provides him with an equal opportunity with respect to positions he can perform" (Chamberlin, supra at D/116). Moreover, while accommodation must not cause undue hardship, it must also be possible. These points were further explored in Bonner v. Ontario (Ministry of Health), supra.

In Bonner, the complainant suffered from a mental handicap characterized by severe depression which required periodic hospitalization and absence from work. The Board found that the complainant's job performance was unsatisfactory and justified his termination from employment at the end of the probationary period, independently of his handicap and that his discharge did not result from any discrimination. However, the Board went on to consider arguments related to accommodation which I find helpful in the particular circumstances of this case which also involve a recurrent illness resulting in unpredictable absences from work.

The Board discussed the problem of providing effective accommodation in the following terms:

> there does not seem to have been any way in which the complainant's handicap could have been accommodated in the sense of enabling him to do the work competently when subject to its symptoms -- as would be the case for instance, if a ramp were installed permitting a physically handicapped employee to perform duties not otherwise possible while remaining confined to a wheelchair. And while the extent and depth of Mr. Bonner's symptoms might fluctuate so that there were occasions when his ability is not notably impaired, circumstances beyond an employer's control might cause them to flare up at any time, once again impeding his ability to function properly for an unpredictable period of time.

Professor Hubbard noted the Commission's submission that Mr. Bonner's probationary period could have been extended. However, he pointed out that in assessing the employer's obligation to do so, it must be established that "doing so would truly have accommodated Mr. Bonner's 'needs' within the meaning of the requirement [to accommodate] and whether it would have involved undue hardship" (at D/496).

In response to a submission that the complainant needed "more time", he responded that the "needs" which the section contemplated "are needs which if met would actually enable the person to perform the work so that it can be said that but for the failure to provide for those needs, the employee would have been able to perform the work" (at D/496). He continued:

> The "needs" must be such that upon their accommodation capacity would occur and it is therefore simply false to assert that the person is presently incapable. The "needs" in question are not needs which, if met, might possibly enable the employee to do the work at some future time (ibid).

He next addressed the issue of the recurrent and unpredictable nature of symptoms of Mr. Bonner's handicap commenting, "the question whether Mr. Bonner is capable of doing the work when symptom-free may well be irrelevant. I would think that the employer's privilege to refuse to hire a person whose handicap renders him or her incapable of doing the work ...

extends to persons whose handicap prevents them from doing the job from time to time for periods of significant duration."

He continued:

> If an applicant were undoubtedly competent when well, so that it was beyond question that he or she would satisfy the requirements of the position when unaffected by the handicap, would it not appear to be unreasonable to require an employer to hire such a person when the recurrent effect of that handicap is that much, if not most, of the time, that applicant will, in fact, be unable to perform the work?

He pointed out that what is to be accommodated is the handicap not the inability and concluded, "if there are no reasonable measures that would enable the employee to perform the work properly, the Code permits discrimination on the basis of the resultant incapacity" (at D/497).

Where effective accommodation is possible, an employer is not required to sustain undue hardship. In Central Dairy Pool, supra, the Supreme Court of Canada (at D/438) outlined factors relevant to assessing "undue hardship", including:

> financial cost, disruption of the collective agreement, problems of morale of other employees, interchangeability of the workforce and facilities. The size of the employer's operation may influence the assessment of whether a given financial cost is undue or the ease with which the work force and facilities can be adapted to the circumstances. Where safety is in issue, both the magnitude of the risk and the identity of those who bear it are relevant considerations.

The Code directs attention in section 17(2) to considerations of "the cost, outside sources of funding, if any, and health and safety requirements, if any." The focus of the provision on cost and health and safety concerns, appears to exclude consideration of disruption of the collective agreement and morale under the Ontario Code. However, to the extent that direct costs, and costs arising from the impact on the organization of the work place and workforce are

implicated, these would appear to be relevant considerations.

With these legal principles in mind, then, I turn to the specific issues in this complaint.

3.1. Was Ms. Burns, because of her handicap, incapable of performing duties or requirements that were essential to the job?

The evidence discussed above established that as a result of her illness, Ms. Burns was unable to perform several aspects of her employment. Indeed, during the majority of her absences she was unable to perform any aspects of her job whether essential or not. The pattern of absences arising from her handicap had an additional effect on her overall ability to discharge many of her responsibilities even when in attendance.

I am prepared to accept, for the purposes of argument, that not all of the duties enumerated in Ms. Burns' job description were essential to the position or, that it was not essential that Ms. Burns herself provide them. Routine administration, outpatient testing and basic respiratory routines could be provided by others. Indeed, the Hospital accommodated Ms. Burns in these areas from an early time despite the additional cost, inconvenience and degree of programme compromise which resulted.

Ms. Burns maintained the position in her testimony that the bulk of her work was made up of outpatient testing and that the majority of her job had been done before she came to the hospital and could be done by 90 per cent of the existing nursing or technical staff "the way it had always been done before" in her absence (eg. Vol. 1 at 33; Vol. 2 at 124). She did admit that absences of around 50 per cent could cause inconsistency in the treatment provided to

patients (Vol. 2 at 152) and that the Hospital had a right to be concerned about the problems her absences were creating for its programme in the Department (Vol. 3 at 48).

However, some elements of the job were clearly essential and problems related to them were accentuated enormously by the fact that Ms. Burns was the Director and sole employee of the unit, and the only R.T. in the hospital. Ms. Burns was not capable of performing several elements of the duties and requirements of her position which I find to be essential. These included:

> * **Establishing the unit effectively as an integrated part of Hospital services:** Ms. Mashinter testified that upon her arrival in the Hospital in April 1990, "the policies and procedures manual was not completed, it was done in a really haphazard manner where alot of photocopying was done and handwritten items were written in instead of typed in more of a professional style" (Vol. 7 at 140). Ms. Galarneau testified that when she began relief work with the testing, she did not rely on the policies and procedures left in the Department by Ms. Burns "because they weren't complete" and she "wasn't comfortable referring to a manual that had three or four different types of pages on different procedures that were being revised. I did not know which of them to follow" (Vol. 6 at 121, 123; see also Exhibit #53). As Ms. Burns' testified that she logged some 85 hours of overtime working on these policies and procedures, I confess to some doubt about whether this indicated an incapacity resulting from her illnesses per se. Clearly something had intervened to prevent this essential work from being completed. The filing and indexing systems suffered badly (Vol. 7 at 140) from incomplete set-up and from the flow of different people doing

pieces of the work. The indexing problem appears to have a continuing effect on patient records. On other matters, it was clear that there was little planning or continuity.

* **Effective functioning as a Director/Department Head:** As a result of Ms. Burns' absences and the tensions surrounding her conduct when present, Ms. Burns' ability to effectively function as a Director was severely limited. Development and supervision of services, and planning in consultation with physicians, nursing staff and her direct supervisor, Ms. Northmore, the Director of Patient Services could not be undertaken.

* **Education of staff:** Exhibit #44 is a memo prepared by Ms. Burns detailing 20 inservice education sessions scheduled between October 30 and November 30, 1989. Sixteen of these sessions were cancelled. Ms. Burns agreed that providing education to nursing staff and doctors was necessary. It seems clear that no consistent education was provided. Ms. Mashinter who replaced Ms. Burns at the Hospital testified that the level of education concerning the role of an R.T. was "very poor" (Vol. 7 at 141).

* **Inpatient Respiratory Work:** The problem of unit establishment and education was again relevant to the inpatient respiratory work. Ms. Northmore's evidence, which I accept on this point, is that the nurses could not count on her being there and thus they did not get into the habit of routinely referring respiratory work. This was a source of frustration. It also meant that planned improvements to patient care through the expansion of services did not take

place. It may well be true, as Ms. Burns' asserted, that "the respiratory work was done by the nurses the way it had always been done before" (Vol. 1 at 33) but maintaining them at such a level was not part of Ms. Burns duties. And, as Dr. Caughey testified, acuity levels were rising and the nurses in 1988 could not be expected to provide the same standard of patient care in terms of inpatient respiratory therapy as an R.T. would be able to deliver (Vol. 6 at 133, 136). Ms. Burns accepted that her role was to expand the scope of the respiratory services and consolidate them into the Cardiopulmonary Department (Vol. 2 at 97). The result was that the fragmented and limited service delivery faced by the Hospital prior to Ms. Burns' arrival remained the almost the same (Vol. 5 at 4. Vol. 6 at 105, Vol. 6 at 144, Vol 7 at 142).

* **Equipment Maintenance**: Ms. Burns testified that she was sometimes able during her hospitalizations at South Muskoka to maintain equipment. However, Dr. Caughey testified, and I accept, that "the machines were not kept up" consistently and that a change over in nursing staff meant that fewer nurses were able to undertake even routine maintenance of existing machines (Vol. 6 at 143; see also Vol. 5 at 82). Ms. Northmore also identified problems with "stock outs" which may have been prevented had Ms. Burns established a requested inventory system.

I should also note that a preliminary assessment in October 1989, under the Quality Assessment Programme confirmed the existence of a number of problems in the department. Ms. Burns did not accept that her illness was the source of these problems, but placed much of the blame on Ms. Galarneau and on Ms. Northmore for not planning properly (Vol. 5 at 66).

This summary of the evidence establishes that, as a result of her handicap, Ms. Burns was indeed incapable of performing a number of essential duties or requirements of her position. The proximate cause of the incapacity was her absences and, more particularly, the unpredictability of her absences and returns to work as a result of her illnesses. The recurring nature of the problem disrupted ongoing work, planning and service development. It was also established that for these elements of the job, an experienced R.T. with management training, was essential. As noted, the Respondents had made arrangements to cover the outpatient cardiac tests and the PFTs which did not need to be given by an R.T. per se. The task facing the Respondents was to assess whether they could, short of undue hardship, accommodate Ms. Burns in relation to her incapacity to perform those essential duties and requirements of the position.

3.2 Could the Respondents have accommodated Ms. Burns in relation to those essential duties and requirements without causing undue hardship to the Hospital?

As noted above, an employer must take substantial and meaningful steps in attempting to accommodate a employee who, because of a handicap, is unable to perform essential duties or responsibilities. They must make an effort to assess whether the employee would be capable of performing those duties if accommodated. This assessment involves a serious, good faith deliberative process by appropriate persons in the work place, considering the options and soliciting the views of of the employee concerned and accurately assessing the financial, health or safety impacts of possible accommodation on the undertaking. The employee has a duty to assist the employer in seeking appropriate accommodation and to co-operate with the process by making their needs known, providing available information within their control, clarifying

matters where necessary and helping to facilitate the process. Accommodation is to be directed to the handicap and to meeting the needs of the employee arising from it in such as way that the employee is enabled to perform essential job requirements. Such accommodation must be both possible and not the cause of undue hardship to the employer.

Having reviewed the evidence and the law, it is my opinion that prior to their letter of January 9, 1990 which resulted in the cessation of Ms. Burns' employment, the Respondents appropriately assessed whether Ms. Burns was capable of performing the essential duties and responsibilities of her position in light of her handicap. The senior management team of the Hospital undertook a careful deliberative process in good faith and in light of the expressed views and requests of the Complainant, Ms. Burns. Ms. Burns did not provide detailed reasons or a plan in support of her request for a leave. Her stance throughout her employment was non-cooperative in relation to various options and efforts made by the Hospital to accommodate her handicap. Ms. Burns refused even to acknowledge that there was a serious problem which required joint efforts to manage. The nature of Ms. Burns' handicap with its resulting recurrent absences from work for unpredictable periods of time very strongly suggests that the leave of absence requested by the Complainant would not have accommodated Ms. Burns' "needs" as arising from her handicap. On all the available information, it would not have permitted her to perform her job. I accept, with Professor Hubbard in Bonner, supra:

> The "need" for a deferral of activity to some future time in the hope that circumstances will change for the better is not a "need" the accommodation of which would enable the person to perform work that he or she is demonstrably unable to perform currently. It is not, in my opinion, a "need" within the meaning of that term as contemplated by the Code.

I also consider that the Hospital fully considered the financial and health (in the sense of patient care) impacts of the proposed accommodation. I would have been prepared to find that, if the only way to accommodate Ms. Burns' would have been to hire a second R.T. on a

permanent basis, this would have constituted undue financial hardship as well as being an inappropriate resolution of the problem.

It follows that I conclude that the Respondents fulfilled their obligation to attempt to accommodate Ms. Burns in relation to the essential duties and requirements which she was unable to perform as a result of her handicap and that her rights to be free from discrimination in employment on the basis of handicap were not infringed by the Respondents.

Issue 4. Could the Hospital's policy, which required two years of service before employees were eligible to receive a general leave of absence, be considered to have an adverse impact on persons suffering from a handicap? If so, did the hospital discharge its obligation to attempt to accommodate Ms. Burns in relation to this policy?

In light of my finding that the Hospital did not rely on the requirement of a two year period of eligibility in the general leave of absence policy, and considered Ms. Burns' request on the basis that she was fully eligible, I find that there was no adverse impact arising from the policy. My remarks on accommodation above would also apply.

Issue 5. If it is found that the Respondents did discriminate against Ms. Burns in her employment or harass her in the workplace because of handicap, what is the appropriate remedy?

In light of my findings that the Respondents did not harass or discriminate against Ms. Burns contrary to the Code, it is not necessary for me to fashion a remedy in this case.

complaint or the conduct of the Commission with respect to it was, in terms of section 41(4) of the Code, "trivial, frivolous, vexatious or made in bad faith" or that "undue hardship was caused to the person complained about" beyond the normal expense, stress and impairment of reputation which can be expected as part of any response to a human rights complaint (cp. Shreve v. City of Windsor (Ont. Bd. of Inq, May 1993, costs). If necessary, I will hear the parties further on this matter and I retain jurisdiction for 45 days in this regard.

ORDER

After a full hearing and review of the evidence and applicable law, the amended complaint of Margo Burns against the South Muskoka Memorial Hospital Board, Patricia Northmore and Frank Lovelock dated April 13, 1992 alleging harassment in the workplace and discrimination in employment because of handicap is dismissed.

T. Brettel Dawson
Board of Inquiry